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Madigan Army Medical Center (MAMC), TRICARE Region 11 and the VA Puget Sound Health Care System (VAPSHCS) formed a task force in September 2001 to determine ways to increase the level of sharing between the organizations. Their efforts lie in the wake of increased fiscal scrutiny the President of the United States and Congress are giving their respective parent organizations, the Military Health System and the Veterans Health Administration (VHA); the country's two largest health care systems. The U.S. General Accounting Office has reported on numerous occasions that these two health care systems are not doing enough to increase the sharing activity between them and that millions of dollars of taxpayer money could be saved if the two systems collaborated more.

This critical look at DOD/VA sharing at MAMC uses retrospective descriptive analysis in an attempt to more accurately portray Fiscal Year 2001 sharing activity between MAMC and the Department of Veterans Affairs, VHA, the Veterans Benefits Administration, and the VAPSHCS. The analysis finds that MAMC's level of interaction with these agencies, as measured by number of services provided and dollar amount of care provided, was significantly higher than previously reported.

The project documents MAMC's and TRICARE Region 11's efforts to form new agreements and increase the overall level of sharing in the Puget Sound Area between September 2001 and March 2002. The researcher uses the United States Army's Business Case Analysis Tool, scenario analysis and breakeven analysis to analyze the financial implications, benefits and disadvantages of the two proposed new agreements and makes recommendations on their implementation.

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U.S. Army – Baylor University  
Graduate Program in Healthcare Administration

Department of Defense/Veterans Affairs Sharing Initiatives  
At Madigan Army Medical Center

A Graduate Management Project Submitted to the Program Director in  
Candidacy for the Degree of Master's in Health Administration

By

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## ABSTRACT

Madigan Army Medical Center (MAMC), TRICARE Region 11 and the VA Puget Sound Health Care System (VAPSHCS) formed a task force in September 2001 to determine ways to increase the level of sharing between the organizations. Their efforts lie in the wake of increased fiscal scrutiny the President of the United States and Congress are giving their respective parent organizations, the Military Health System and the Veterans Health Administration (VHA); the country's two largest health care systems. The U.S. General Accounting Office has reported on numerous occasions that these two health care systems are not doing enough to increase the sharing activity between them and that millions of dollars of taxpayer money could be saved if the two systems collaborated more.

This critical look at DOD/VA sharing at MAMC uses retrospective descriptive analysis in an attempt to more accurately portray Fiscal Year 2001 sharing activity between MAMC and the Department of Veterans Affairs, VHA, the Veterans Benefits Administration, and the VAPSHCS. The analysis finds that MAMC's level of interaction with these agencies, as measured by number of services provided and dollar amount of care provided, was significantly higher than previously reported.

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## Department of Defense/Veterans Administration Sharing Initiatives

### At Madigan Army Medical Center

The Departments of Defense (DOD) and Veterans' Affairs (VA) had a combined annual health care budget of approximately \$34 billion for Fiscal Year (FY) 1999. The DOD spent about \$16 billion to provide care for approximately 5.8 million beneficiaries, while the VA spent about \$18 billion to provide care for approximately 4.1 million beneficiaries (General Accounting Office, May 17, 2000; Department of Defense, 2001). The DOD's health care arm, otherwise known as the Military Health System (MHS), is comprised of the Assistant Secretary of Defense for Health Affairs (ASD/HA) and the medical departments of the Army, Navy and Air Force. Likewise, that portion of the Department of Veterans Affairs responsible for health care is known as the Veterans Health Administration (VHA).

The DOD provides healthcare to its beneficiaries via a program known as TRICARE. TRICARE is a "regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors" (DOD, 2001). TRICARE was developed to improve access to health care while maintaining the DOD's medical readiness posture. It is comprised of the health care assets of the Army, Navy and Air Force, and is supported by networks of civilian health care providers through various TRICARE contracts. It provides beneficiaries with three options for care: TRICARE Prime, TRICARE Extra, and TRICARE Standard.

TRICARE Prime is similar to a civilian Health Maintenance Organization (HMO). In this option, beneficiaries are assigned a Primary Care Manager (PCM) and receive the majority of their care either within a Military Treatment Facility (MTF), or from one of the

network providers. There are currently no beneficiary out-of-pocket costs associated with this option and is the only option available for active duty military personnel.

TRICARE Extra is similar to a Preferred Provider Option (PPO). Beneficiaries choose their providers from a network list of participating providers. Users must pay a deductible and copayment, but the copayment under this option is 5% less than that under TRICARE Standard. This option gives users greater provider choice than TRICARE Prime, but costs the user less than TRICARE Standard. Also under this option, providers file all claims paperwork, alleviating beneficiaries of an additional burden. Users have the option of receiving care within the MTF on a space available basis or they can use TRICARE Standard.

TRICARE Standard is a Fee-For-Service (FFS) option. This option allows the user to choose any health care provider, giving the user the greatest amount of choice. This option is also the most expensive option for the beneficiary, as the user must pay deductibles and copayments when he wishes to obtain care. Also, the user may be "balance billed" under this option. This occurs when the provider used is not a member of the network and the bill exceeds the maximum charge allowed by TRICARE. The user is then responsible for that amount above the maximum allowed charge, not to exceed 15 percent. Beneficiaries with this option can use TRICARE Extra and can also obtain care in an MTF on a space available basis.

As noted earlier, TRICARE is regionally managed. As such, there are 16 regions total: 11 regions in the continental United States, one in Europe, one that includes Alaska and Hawaii, one that covers the Western Pacific (Korea, Japan, etc.), one covering Canada and Latin America, and one for Puerto Rico and the U.S. Virgin

Islands. Madigan Army Medical Center (MAMC) falls within TRICARE Region 11, also known as TRICARE Northwest (NW). The region includes the states of Washington, Oregon, and six counties in Northern Idaho in close proximity to the MTF at Fairchild Air Force Base, near Spokane, Washington.

Madigan Army Medical Center (MAMC) is a level III, 414-bed Military Treatment Facility (MTF) at Fort Lewis, situated just south of Tacoma, Washington. The hospital had a FY01 budget of approximately \$153 million, and provided care to over 175,000 beneficiaries (Madigan Army Medical Center, 2001). This budget figure does not include salaries for military personnel. The hospital, as well as belonging to TRICARE Region 11, also falls under the Army Medical Department's Western Regional Medical Command (WRMC).

The Western Regional Medical Command is one of the Army's six Regional Medical Commands (RMCs), responsible for providing command and control over all Army Medical Department (AMEDD) units within each particular region. The WRMC span of control encompasses the states of Alaska, Washington, Oregon, California, Idaho and Nevada, and also provides support to the Army Reserve and National Guard units within those states.

Madigan maintains a staff of over 3000 personnel, and has 27 different physician training programs and two nursing programs. Of its roughly 1100 military personnel, 672 are designated to fill medical positions within 58 different units during time of war, that are vacant on a normal day-to-day basis. This system is known as the Professional Filler System or "PROFIS" system. Most active component and reserve component units do not have the medical personnel they would have in time of war. These medical

personnel are assigned to a medical treatment facility, such as MAMC. Other occasions during which these medical personnel can be "pulled" from MAMC are when these units deploy to conduct various training exercises, or for other training requirements. When MAMC loses these personnel to other units, reserve component medical personnel can be called to active duty to fill their positions. Many times however, there is a time lag between when MAMC gives up its personnel and when it gets replacements for them. Also, there may not be replacements for all of the positions given up. Another challenge for military hospitals is that a replacement from the reserves may not have all of the particular skills or be of the same specialty as the person who left. These factors have the potential to impact MAMC's ability to deliver of care by causing the hospital to possibly reduce the level of services it provides, or at a minimum, by creating some turbulence and inefficiency in the normal flow of operations due to personnel turnover.

One way to reduce the impact is to send the patient to a network provider. TRICARE is set up in such a way, that if the MTF cannot provide care within established access time standards, the patient has the option of being seen by a civilian provider who is a member of the preferred provider network. Network provided care typically costs the MTF more than if it is provided in-house.

Another option available to DOD that could reduce the financial impact and "turbulence" could be through well coordinated sharing agreements with Department of Veterans Affairs (VA) health care facilities. In fact, according to a United States General Accounting Office report, MTF's saved money when VA provided care was used, as compared to what it would cost if patients were sent to civilian network providers (GAO, April 1995, May 17, 2000).

In the Puget Sound area, the VA has two medical centers proximal to MAMC. The American Lake VA hospital, which started out as an Army neuro-psychiatric facility in the 1920's, is approximately 6 miles from MAMC, while the Seattle VA hospital is about 45 miles away from MAMC. These two facilities, or campuses as the VA calls them, operated independently until 1995 when the VA reorganized into 22 Veterans Integrated Service Networks (VISNs). These VISNs were organized on a regional basis for much the same reason that the TRICARE regions were organized. Under this reorganization, the two campuses combined to form the VA Puget Sound Health Care System (VAPSHCS) and became part of VISN 20. VISN 20 includes the states of Alaska, Washington, Oregon, and Idaho.

In FY99, VAPSHCS maintained an annual budget of 220.6 million, providing services to almost 46,500 beneficiaries during that time (VA Puget Sound Health Care System, 2001). The VAPSHCS specializes in spinal cord injuries, bone marrow transplantation, cardiovascular surgery, mental health care, cancer care, and blind rehabilitation. The VAPSHCS also fosters an active academic affiliation with the University of Washington, training over 500 students and residents in various specialties, and maintains the VA's fourth largest research program (Department of Veterans Affairs, 1999).

According to Debbie McVey, Support Agreement Manager for the WRMC, MAMC and VAPSHCS have 12 active sharing agreements (See Appendix A). Ten agreements cover various Graduate Medical Education (GME) and other education programs. Under these agreements, medical interns and residents from both systems receive training and provide care in each other's facilities. There is no exchange of funds associated

with these agreements. One agreement covers Emergency Response, whereby the VA would provide back up medical support to MAMC in the event of war or national emergency and activation of the National Disaster Medical System (NDMS). Currently, there are no fund transfers associated with this agreement. The last agreement is the only one of the 12 where funds are exchanged. This agreement covers several inpatient and outpatient services that MAMC staff provide to VAPSHCS for which MAMC receives reimbursement. Under the agreement, VAPSHCS also provides MAMC with the service of a Geriatric Fellowship Director for which MAMC reimburses VAPSHCS for a portion of the director's salary and benefits. This was not discovered initially based on the information's absence from the document in Appendix A. The \$52,000 MAMC paid VAPSHCS and the \$175,000 of worth of services MAMC staff provided VAPSHCS yield a combined amount of \$227,000 in service provided between MAMC and VAPSHCS. This amount gives an indication of the amount of sharing the two organizations did in FY01. To put this amount into perspective however, consider that this accounts for less than two tenths of one percent of Madigan's budget alone for that year. For most sharing agreements, monetary figures alone cannot normally give a true picture of the extent of sharing, due to "bartering" that generally occurs between facilities. Using the numbers of episodes of care in addition to a dollar value for bartered services would help provide a more accurate picture, but are currently not tracked very well by either DOD or VA medical facilities. In Madigan's situation however, there appeared to be no bartering agreements therefore, the percentage given was indicative of the level of sharing at that time.



Conditions which prompted the study

The Military Health System (MHS) and the Veterans Health Administration (VHA) are both coming under increased scrutiny, particularly in the area of fiscal management. The "draw-down" of U.S. military forces during the 1990s came with an associated reduction in the military budget. But, although the number of military personnel was significantly reduced, the number of health care beneficiaries and amount of health care workload did not decrease at an equivalent rate. Programs such as TRICARE Senior Prime, now known as TRICARE Plus, gave thousands of patients over age 65 *guaranteed* access to care within a Military Treatment Facility. This access was previously granted on a space available basis only. Granting this group guaranteed access came with a corresponding increase in MTF workload. And just like their civilian health care counterparts, the MHS and VHA were feeling the financial impact of the soaring costs of health care. In the face of reduced funding, increased workload, and rampant inflation, terms such as balanced scorecard, business plan, optimization, re-engineering, and return on investment quickly became part of these organizations' vernacular.

The AMEDD is currently implementing a management tool known as the "balanced scorecard." Dr. Robert Kaplan and Dr. David Norton developed the process, which basically helps an organization translate its strategic plan into measurable goals and objectives (Balanced Scorecard Institute, 2001). The tool provides managers concrete data with which they can monitor the organization's processes and progress. On The Surgeon General of the Army's (TSG) balanced scorecard, one of the strategic themes regarding AMEDD internal processes is to "Implement clinical and best business

practices." The underlying objective for this theme is to "systematically identify and implement...best business practices". As it applies to this paper, if we cannot provide all necessary care within the MTF, we should then seek health systems that will: provide care of a quality equal to or greater than that provided in the MHS, meet or exceed our access standards, and do all of this at the lowest cost to our organization and its stakeholders. Another of the Surgeon General's strategic themes regarding the AMEDD's financial processes is to "operate within budget." The MTF commander needs to utilize his funds as efficiently and effectively as he can, and needs to have a monitoring process in place to track how well his organization is performing. The draft version of Madigan's balanced scorecard (BSC) is a reflection of the AMEDD's balanced scorecard, reiterating the importance of doing what makes good "business sense."

Additionally, the GAO has addressed ways to make better use of our funds through several reports on the subject of DOD/VA sharing initiatives. These reports highlight millions of dollars of cost avoidance due to initiatives already in place, but emphasize that hundreds of millions of dollars could be saved each year through additional sharing agreements (GAO, January 2000, May 17, 2000, May 25, 2000). These reports also indicate the "VA and DOD need to increase joint activities to maximize federal health care resources" (GAO, January 2000), and if they cannot agree on how to do this "within a reasonable amount of time, Congress should consider providing direction and guidance that clarifies the criteria, conditions, roles and expectations for...collaboration" (GAO, May 17, 2000). This is a fairly strong signal that if we, the MHS and VHA,

VAPSHCS and MAMC, cannot recognize and act on sharing opportunities, it is likely someone else will dictate when, how, and how much sharing will occur.

Another "signal" indicating that DOD/VA sharing needs reevaluation is the issuance of an Executive Order establishing the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans on May 31, 2001. The task force's charter is to develop recommendations "for how to improve health care to U.S. veterans and military retirees through increased coordination between DOD and VA" (Butler, July 2001; The White House, 2001). This task force must report back to the President within nine months, but has up to nine additional months to formulate recommendations. The task force seems to be moving quickly, as it held its first meeting October 10, 2001 and was already visiting multiple sites in Alaska during the very next week to obtain the perspectives of various stakeholders involved in the Alaska Federal Health Care Partnership.

In April of this year, Stephen P. Backhus, Director of Health Care – Military Health Care Issues, United States General Accounting Office, sent a letter and questionnaire to MAMC' Commander. The letter stated, "Based on general criteria including proximity to a VA or DOD hospital, current sharing arrangements, and medical education programs, we identified Madigan Army Medical Center and the VA Puget Sound Health Care System—American Lake as a potential site for additional sharing." The letter asked the MAMC Commander to provide information regarding current sharing activities and other information that would be used by GAO to gauge opportunity for future sharing activities.

On July 27, 2001, the Honorable Christopher Smith, Chairman, House Veteran's Affairs Committee, United States House of Representatives, introduced the Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001 (HR 2667)(House Committee on Veterans' Affairs, 2001). This bill, if passed, will in effect "require" DOD and VA to share resources. This is yet another powerful signal to DOD and VA, one that not only beats the same drum, but amplifies the message that progress in sharing needs to happen quickly, else it may be forced upon us.

The leadership of VISN 20, the WRMC, and TRICARE Region 11 received the message sent by GAO, the President, and Congress. They brought MHS and VHA personnel together at a DOD/VA Health Care Summit on September 6, 2001 and directed the formation of a local DOD/VA task force. Dr. Les Burger, Network Clinical Manager for VISN 20 and former Commander of MAMC, and Brigadier General Farmer, Lead Agent for TRICARE Region 11 and the WRMC Commander, chose co-chairmen for the joint task force and gave them the mission to identify and make recommendations on how to improve DOD/VA sharing in the Puget Sound Area. Dr. Gordon Starkebaum, VAPSHCS Medical Director, represents the VA as one co-chairman and Colonel Tony Carter, Deputy Commander for Clinical Services (DCCS) at Madigan Army Medical Center, represents the MHS as the other. Individuals representing the various service lines of each organization comprise the task force. The goal for these "teams" was to individually identify any need and/or excess they may have, whether it is personnel, procedures/services, space, access, or equipment. Individuals were to communicate this information with his or her counterpart to

determine where sharing could occur, given the current resources. A formal process for evaluating each proposed initiative was not established at that time. That is where this investigator entered the picture: to monitor the individual teams progress, collect information from each service line team, and if a potential worthwhile initiative was identified, to formally evaluate those potential initiatives in order to determine the impact on MAMC, VAPSHCS and the patient.

#### Statement of the problem or question

The questions that need answered are: What is the current sharing baseline for MAMC and VAPSHCS? In what areas do opportunities to improve sharing between VAPSHCS and MAMC exist? Of the opportunities identified, which ones should MAMC leadership pursue, which ones should it not pursue, and why? How will MAMC staff measure, monitor, and track the "level" of sharing. How will increased sharing impact the overall delivery of health care at MAMC and how can MAMC staff measure this?

#### Literature Review

In May of 1982, Congress enacted Public Law (PL) 97-174, the VA and DOD Health Resources Sharing and Emergency Operations Act, promoting DOD/VA sharing. The original impetus behind the Act was to give the VA and DOD the vehicle necessary to create sharing initiatives on their own, with the ultimate goal of containing their rapidly increasing health care costs (House Committee on Veterans' Affairs, July 27, 2001). Public Law 97-174 "dramatically facilitated sharing arrangements between VA and DOD health care facilities. Virtually all VA medical centers and nearly all military treatment facilities (MTFs) have been involved in sharing agreements under this authority" (Testimony, 2000).

In 1995, legislation allowed VA facilities to participate as providers as part of the TRICARE Network (Testimony, 2000). A telephone conversation with Ms. Sally Knowler of Health Net Federal Services (HNFS), the TRICARE Region 11 Managed Care Support Contractor (MCSC), on October 11, 2001, confirmed that several VA facilities in the Western Regional Medical Command's area of responsibility are sub-contractors of HNFS, to include the American Lake Campus. In essence, one agency of the Federal Government, DOD, is paying a third party, HNFS, to arrange health care and services from another agency of the Federal Government, VAPSHCS. Even a layperson could recognize that this was probably not the smartest way to do business.

According to Ms. Gail Eck, Administrative Officer for VAPSHCS, during FY00 VAPSHCS submitted \$564,517 in bills to Health Net Federal Services for medical care provided to DOD beneficiaries. The VAPSHCS collected only \$188,827. A similar situation existed for FY01 also. That year VAPSHCS submitted bills totaling \$669,876 to Health Net Federal Services. As of December 2001, VAPSHCS had only collected \$34,658. Ms. Eck said that according to the contract VAPSHCS has with Health Net Federal Services, the rate for reimbursement is 80% of the Champus Maximum Allowable Charge (CMAC) rate. The reimbursement rate for MAMC's agreement with VAPSHCS is 100% of CMAC.

In 1997, VA and DOD agreed on a national policy, creating a joint program directed at separation physical examinations for individuals separating from active duty military service. This policy in effect, eliminated the need for two separate exams: one conducted by DOD prior to discharge and the other conducted by the VA when a former service member filed for disability compensation. This single "streamlined" process

saved time and effort for both the departments and the individual service member, while saving money for DOD and the VA. This process also reduced claims processing time by over two-thirds (Department of Veterans Affairs, December 4, 1997, US Army Medical Command, August 21, 1997).

In 1999, Pubic Law 105-261, the Defense Authorization Act was passed. This law "strongly endorsed ongoing VA and DOD efforts to share resources and encouraged expansion of both health resource sharing and VA participation in the TRICARE program" (Testimony, 2001). Additionally in 1999, the Congressional Commission on Service Members and Veterans Transition Assistance recommended that DOD and the VA health care systems form "a closer partnership" in order to maximize economies of scale purchasing efforts (GAO, February 12, 2001).

Although progress has been made, the General Accounting Office (GAO) and members of Congress feel that the DOD and the VA have not done enough over the last 20 years to implement sharing initiatives. A GAO report entitled "VA Challenges", stated "VA and DOD need to increase joint activities to maximize federal health care resources in an effort to save federal dollars". Another GAO report published in February of 2001, goes so far as to say that the "VA and DOD must move towards a true partnership if they are to continue to succeed." Yet another GAO report from May 2000 said that for FY98, the amount of reimbursements reported by the DOD and VA were "less than one percent of their combined health care budget of \$34 billion." This same report also noted that the vast majority of sharing occurred at only a small number of facilities.

The most damaging comments come from Representative Smith, Chairman of the House Committee on Veteran's Affairs. In testimony to Congress, he stated, "the modest scale of these efforts, even twenty years later, continues to beg several questions; why hasn't more been done? What impediments stand in the way of more resource sharing? Why are the Departments not more fully exploiting apparent resource sharing opportunities? This is particularly troubling when we are all working to fully fund both the Defense and Veterans health programs." Representative Smith's thoughts on DOD/VA sharing are so strong, that in May of this year, he introduced H.R. 2667, the Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001. Congress has not yet enacted this legislation, but the bill has strong support and even stronger implications. Whereas other legislation "permitted" or "encouraged" sharing, leaving execution to the DOD and VA, this piece of legislation *directs* the DOD and VA to choose five sites for a demonstration project, where Military Health System and VA medical resources will be fully integrated. The bill would require a "unified management system", to include "budget and financial management... staffing and assignment; and, medical information and information technology systems" (House Committee on Veterans' Affairs, 2001).

The Honorable Mr. Smith, the GAO, and others indicate that there are significant benefits associated with sharing between the DOD and VA, several of which are already noted throughout various portions of this paper. With few exceptions, almost every reference listed at the conclusion of this paper address the benefits of sharing. Rather than list every benefit attributed to each and every reference, most of them redundant, findings of the GAO Report "VA and Defense Health Care: Evolving Health Care



Systems Require Rethinking of Resource Sharing Strategies", May 17, 2000, speak very well for the volume of literature. The report is an assimilation of information from surveys sent to every DOD and VA facility listed by their respective Departments as having some sharing relationship. Not an exhaustive list, the benefits that were most often reported include increased facility and resource utilization, increased revenue, increased staff medical proficiency, reduced costs, improved access, and improved patient satisfaction. Another GAO report, focusing on pharmaceutical purchases, notes that while joint efforts in that arena have already resulted in some savings, further joint efforts have the potential to save as much as \$300 million every year (GAO, May 25, 2000).

Though sharing obviously has its advantages, it normally does not come without its share of challenges. One significant barrier to full integration is the difference in the two cultures. One officer at Bassett Army Community Hospital in Fairbanks, Alaska, participating in the Alaska Federal Health Care Partnership (AFHCP), observed that the differences in DOD and VA organizational cultures keep the facility from truly integrating. Other barriers identified at a VA/DOD Summit conducted at McCord Air Force Base, WA September 6, 2001, include difficulties with reimbursement of services provided and lack of common medical information and information technology systems. The results of the GAO's 1998 survey of VA and DOD health care facilities indicated that the most commonly given barrier was distance between facilities. This is not the case in the Puget Sound Area. Here, it is not uncommon for the VA to send patients living within a 20-mile radius of DOD facilities an additional 20-60 miles to the VA Seattle Campus for care. The entire process of driving to Seattle, receiving care, and

returning home, can easily encompass an entire day's worth of time. It would be much more convenient for the patient to be seen in the DOD facility and would most likely improve patient satisfaction. Two additional barriers given in the report are policies governing reimbursement and budget and processes for approving sharing agreements (General Accounting Office, May 17, 2000). One example of this is that VA guidance calls for the use of incremental costs when calculating reimbursements, but some VA facilities continue to use total cost of care when billing DOD facilities. Another example is that in some locations, DOD and VA facilities try to shift responsibility to each other for treatment and payment of dual eligible beneficiaries (GAO, May 17, 2000), which impedes efforts to form sharing agreements. Dual eligible beneficiaries are those individuals who are entitled to veterans' benefits and also eligible for TRICARE benefits. These are typically military retirees who have some form of service-connected disability. One additional, more recent barrier, stems from a DOD legal opinion on policy and guidance concerning TRICARE support contracts. It seems that DOD policy "prohibits military treatment facilities (MTFs) from using sharing agreements with VA for direct medical care" (GAO, May 17, 2000). This barrier in particular has the potential to be the most problematic. Much confusion still surrounds the policy though, so much so, that the GAO recommended that DOD reevaluate the policy and its stance regarding it.

Apparently there are enough barriers and challenges to sharing, that one of the newly formed Presidential Task Force's goals is to specifically look at those barriers that impede DOD/VA sharing coordination, and make recommendations on how to overcome them (Butler, July 2001). Additionally, one of the mandates in the proposed bill, H.R. 2667, is to identify the challenges to integrating co-located military and VA

health care facilities. Another way that the bill seeks to eliminate barriers is to empower each Department's Secretary to waive regulations and administrative policies that impede the purposes of the demonstration project. One can see that challenges and barriers do exist, but that should not prevent DOD and VA health care facilities from trying to find ways to improve current sharing efforts.

### Purpose

This purpose of the project was to: (1) accurately depict the level of sharing as of September 2001, to be used as a baseline from which to measure changes in the level of sharing, (2) document the progress that occurred toward developing additional sharing initiatives in the Puget Sound area between September 2001 and March 2002, (3) identify those areas (service lines) that hold promise for future sharing opportunities, (4) analyze those prospective sharing opportunities that are most developed and closest to implementation using the United States Army's automated Business Case Analysis (BCA) Tool, to determine each initiative's financial viability and any other benefits and risks associated with the initiative, and (5) make recommendations to the MAMC staff regarding the outcomes of the analyses. The analyses and recommendations incorporate the tenets of cost, quality and access, healthcare's "iron triangle," not only from the perspective of MAMC and its beneficiaries, but also that of VAPSHCS and its beneficiaries as well.

## METHODS AND PROCEDURES

### Ethical Considerations

The researcher considered ethical issues throughout the development of this project. Although the researcher viewed patient specific data in an attempt to identify

specific beneficiary categories, i.e., for dual-eligibles versus "pure VA" patients, none of this information is presented. The researcher made every effort to be objective in his research and to avoid allowing the biases of those interviewed to influence the discussion, recommendations, or conclusions given.

### Assumptions

The researcher made several assumptions with regards to this project. First, the researcher assumed that both organizations would actively participate in the process and work together in the spirit of teamwork and collegiality. It was assumed that those who were asked for information would provide the information as requested and that the information given would be accurate. The researcher also assumed that he would be able to obtain the information necessary to accurately depict the organizations' baseline level of sharing.

### Data Sources

The primary sources of data for establishing the baseline level of sharing were the WRMC Support Agreement Manager, the financial analyst from MAMC's Resource Management Division (RMD) responsible for billing VAPSHCS for the services that MAMC provides, and the personnel from the individual departments that were listed as having sharing activity with VAPSHCS. Secondary sources of data for this information include the Ambulatory Data System (ADS) for outpatient visits, Standard Inpatient Data Record (SIDR) files via the All Regional Server (ARS) Bridge and the World Wide Workload Report (WWR) for inpatient data, and the Medical Expense and Performance Reporting System (MEPRS) Executive Query System (MEQS) III and the Expense Assignment System IV (EAS IV) for cost data. The researcher obtained military pay

data from the U.S Army Personnel Command (PERSCOM) Medical Corps web site and civilian pay from MAMC's Human Resources (HR) Department.

Primary sources of information for the ongoing efforts towards finding and establishing new sharing opportunities were the various MAMC and VAPSHCS team members and work groups who emerged from the task force organization. The researcher used MEPRS, MAMC's Personnel Administration Department (PAD) staff, CPT codes, and the 2002 CMAC rates based on MAMC's zip code to derive the cost data for the business case analyses. Secondary sources of data included the DOD/VA Project Officer for TRICARE Region 11 Lead Agent's Office, MAMC's Chief of Clinical Support Division, and Madigan RMD staff.

#### Reliability and Validity

Most of the data presented in the original FY01 Sharing Summary Worksheet (See Appendix A) is not valid or reliable. The reason for this is that the data reflects what VAPSHCS agreed to be billed for rather than what actually occurred during the year. It is impossible to determine what the numbers in the Frequency of Service Provided Column stand for, although they most closely reflect the number patients seen for each service. The dollar values are correct, but as indicated previously are a reflection of what VAPSHCS agreed to pay rather than what was actually billed. Also, the sharing agreements presented on this worksheet are supposed to be active agreements. This is somewhat misleading, as they are considered active only by virtue of their expiration date if any, rather than by actual participation in the agreement. An additional indication of the lack of reliability and validity of this worksheet is that not all of the interactions between MAMC and VAPSHCS are displayed nor all data elements present. In defense

of this worksheet however, given the tracking mechanisms during that time frame, it would be difficult to provide better data.

The data presented in Appendix B, the Revised FY01 Sharing Summary Workbook presents more data than its predecessor, but the values for Number of Patients and Number of Visits/Services are also of dubious quality. The researcher sought data from numerous sources, but was unable to reconcile the data between any of the sources.

Two examples of this are in reference to the number of VA patients seen and number of visits. The Madigan staff member responsible for collecting the VAPSHCS issued authorization statements for VA patients receiving care at MAMC is the primary source for the information presented in Appendix A. The researcher also presents much of this same information in Appendix B. Appendix B indicates that a MAMC staff saw a total of 203 VA patients during FY01, but does not provide complete data for number of visits. Madigan's data systems on the other hand, indicate that MAMC staff saw 332 VA patients and show a total of 964 visits. Part of the problem lies in distinguishing between dual eligible patients and those who are "pure" VA. Another problem is that some VA patients show up at Madigan without authorization from VAPSHCS, but are seen anyway. Many of these patients present through MAMC's emergency room.

The workbook does present all MAMC sharing interactions with the VA during FY01 and provides accurate numbers for MAMC residents/students trained at a VAPSHCS facility. The dollar values for the training agreements are rough estimates based on regular military compensation and any special pays for residents at the rank of Captain with 5 years of service, and Instructors at the grade of Lieutenant Colonel with 12-14 years of service. Actual residents and instructors will vary in rank and time in

service. The researcher did not intend to present exact figures, rather estimates in a quest to present more quantifiable information pertaining to the level of sharing.

This information serves as a call to develop better mechanisms for tracking MAMC's sharing agreement activity. However, every service line within Madigan that has any interaction with VA patients needs to track the numbers of patients and services provided before data reliability and validity at the aggregate level will improve.

The methodology presented in the Business Case Analyses is valid, but the data used is based only on the past experience and assumptions of those subject matter experts for each of the initiatives. Since there is no way of knowing exactly how many patients each service line will see under the proposed agreements or what conditions those patients will present with, the resulting values of the analyses are not accurate. As such, the researcher used a range of values in the analyses to include minimal, maximal and most likely values. The researcher also used conservative values throughout the analyses so as not to overly inflate or deflate the final results. The analyses do however, give a valid indication of the each initiative's financial viability and provide valuable information for decision-making purposes.

#### Methods and Procedures

The first step in this study was to capture the FY01 baseline amount of sharing for the two organizations. At first this seemed like it would be a relatively easy task. The WRMC Support Agreement Manager already had a spreadsheet that was capturing the information. Upon further examination, the researcher found that there were missing data elements from the spreadsheet and that the services each organization provided and their associated reimbursements did not match what was presented in the actual

agreement. The researcher also discovered that not all of the agreements were "active." Several of the agreements, particularly those involving Graduate Medical Education and other training, are listed as active in that the end date for the agreement has not passed, but in reality have no students participating in them. These findings caused the researcher to seek additional sources of information.

The most likely candidates for this information, which was hopefully more accurate, were the actual clinics who provided the services to VAPSHCS. The researcher found however, that there were varying levels of tracking from clinic to clinic. On one extreme, there was no tracking performed by clinics such as the Department of Radiology and Ophthalmology, two of the largest providers of services to VAPSHCS. On the other end of the spectrum was the Department of Pathology and transfusion services, which had a very detailed itemized list of by patient, by CPT code, per visit information to include accurate dollar amounts with which to bill VAPSHCS.

For each of the medical services, the researcher obtained data for the number of patients who utilized the service, the total number of services provided, and the dollar amount billed for services provided base on the prevailing reimbursement rate. Since some patients utilized various services on multiple occasions, the researcher included total number of services provided because it gives an additional dimension and more accurate depiction of the amount of sharing activity.

For those agreements considered as "bartering agreements", e.g., GME and other training agreements, the researcher obtained the number of residents/students involved in training during FY01 and the number of days each spent at a VAPSHCS facility. The researcher also calculated an hourly rate for services provided by each of the residents



and associated staff members to generate a value for the time spent providing patient care and for the instruction given. This rate was based on 50% of the individual's time being involved in the learning process and the other 50% being devoted to patient care activities. The researcher used regular military compensation figures only for enlisted soldiers and added any applicable specialty pay amounts for the officers (Office of the Secretary of Defense, 2002; U.S. Army Medical Corps Branch, 2002).

For new sharing agreements, the researcher utilized the capacity versus need matrix that the local DOD/VA Sharing Task Force developed to identify those purely medical service lines where potential sharing agreements could develop (Chronister, September 16, 2001). The input of the various service line managers from both MAMC and VAPSHCS served as the basis for the matrix's development. The matrix showed the medical service lines in which a particular organization had excess capacity to perform additional services and those service lines in which each organization had a need for additional services. By matching one organization's excess with the others needs, three medical service lines emerged where potential sharing arrangements could form. These service lines are for otolaryngology services, obstetric and gynecology services, and mental health services. In addition to these three service lines, task force members identified five additional areas where additional sharing opportunities were likely to develop. These five areas include pharmacy, regional contracts, information management/information technology, nursing services, and laboratory services (Chronister, October 5, 2001).

The managers for these service lines then communicated more detailed information regarding each other's needs and capacities to determine whether an amicable

arrangement could possibly form. The researcher monitored the progress of each service line by direct contact with the service line managers and through attendance at numerous sharing coordination meetings. To date, two service line's efforts have progressed to the point that new sharing agreements are being made. These two service lines are otolaryngology and OB/Gyn. The researcher conducted business case analyses for the two proposed ventures to determine their viability and presents additional advantages and disadvantages associated with the proposals. The researcher also utilized breakeven analysis and scenario analysis techniques in developing the values used in the business case analyses in order to present MAMC leadership with the entire spectrum of possibilities. The researcher discusses not only these two initiatives, but also the overall sharing efforts to date and makes recommendations concerning the two initiatives and the overall sharing process herein.

## THE RESULTS

The first objective was to more accurately depict the full extent of interaction that MAMC has with the VA. Though the researcher succeeded in presenting a more accurate depiction, he fell far short of his naïve goal of 100% accuracy. Given the current tracking and reimbursement mechanisms, the researcher believes that obtaining 100% accuracy for the retrospective data is impossible.

The spreadsheet at Appendix A is the original spreadsheet and information that the WRMC Support Agreement Manager used to report sharing activity during FY01. The researcher presents a revised version of this spreadsheet in Appendix B, which is a more accurate and detailed depiction of the sharing activity for FY01, but as highlighted earlier is far from perfect. A comparison of these two spreadsheets shows the following

changes: the addition of number of patients and number of visits or services provided, the number of students and hours spent at one of the two VAPSHCS facilities, a dollar amount indicating the value of services provided by each organization for the "bartered" agreements, and additional status columns indicating whether or not a particular agreement is active, the expiration date for the agreement, whether or not the agreement is under revision, and if under revision, the status of the revision. One sees that the revised version of the spreadsheet presents a completely different picture of MAMC's sharing activity.

Also included are data for contracts and agreements that MAMC is participant in with various VA entities other than VAPSHCS. These include the Department of Veterans Affairs, Veteran's Benefits Administration, and the Veterans Health Administration. This information serves to provide a picture of MAMC's *total* involvement with the VA.

The second objective was to monitor MAMC's and VAPSHCS's efforts to identify and implement new sharing opportunities. Local DOD/VA Sharing Task Force members identified seven areas that would most likely yield new sharing opportunities and it is in these areas that they have concentrated their efforts. These efforts areas include Medical Services, Nursing, Pharmacy, Laboratory, Regional Contracts, Mental Health, and Information Management/Information Technology (IM/IT).

From these areas, two service lines have developed definitive proposals for new sharing agreements. These two service lines are otolaryngology and obstetrics/gynecology. This is not to say that this is the only progress made thus far, rather that these two service lines are the only ones that are presently beyond the discussion phase and are ready to implement their proposals. As such, the researcher

presents information pertaining to all service lines other than otolaryngology and OB/Gyn in the discussion portion of this paper.

The researcher conducted business case analyses of the otolaryngology and OB/Gyn proposals. These are found in Appendices C and D respectively. Highlights of the analyses are presented here.

The otolaryngology proposal involves MAMC providing a staff physician and resident to see VAPSHCS patients at the American Lake Campus for one half day per week. Madigan physicians estimate that they will see 25-30 patients per week in the half-day clinic. The Chief of Staff for VAPSHCS estimates that approximately 25 VA patients seen per year in the clinic will require surgery. The MAMC staff physician in the clinic will refer those patients seen who require surgery to MAMC for their procedures. Total estimated dollar value of the inpatient care based on MAMC's cost to provide that care is approximately \$112,000. Based on current reimbursement procedures, VAPSHCS will most likely pay MAMC approximately \$75,000 for that care. The benefit to GME, benefit to the patient, and benefit to VAPSHCS outweigh the \$37,000 negative return on investment for Madigan. This proposal is currently in written form and awaiting approval of VAPSHCS leadership in Seattle. The researcher presents more detailed information in the discussion portion of the paper and also in the business case analysis in Appendix C.

The proposal for OB/Gyn services involves American Lake Campus physicians referring those VA patients requiring OB/Gyn care to MAMC. The American Lake Campus has no OB/Gyn physicians. The Chief of OB/Gyn at MAMC estimates that his department will see approximately 2-5 new VA patients per week. These patients will

require multiple visits and most likely multiple outpatient procedures. A minority of the patients will also require inpatient procedures. Total estimated dollar value of the care based on MAMC's cost to provide the care is approximately \$40,000. Based on current reimbursement procedures, VAPSHCS will most likely pay MAMC approximately \$151,000 for that care. The patient, MAMC and VAPSHCS benefit from this proposal. Again, more detailed information regarding this proposal is given in the discussion portion of the paper, as well as in Appendix D.

### DISCUSSION

The summary document that MAMC uses to keep track of annual sharing data does not accurately depict the total amount of collaboration that MAMC has with the VA (see Appendix A). The researcher identified one glaring example of this while comparing the scope of agreed upon services and the associated reimbursement with information presented in the summary spreadsheet. The researcher assumed that when he began this project, that VAPSHCS was providing no reimbursable services for MAMC beneficiaries. The researcher based his assumption on the information presented in MAMC's FY00 and FY01 sharing summary spreadsheets. According to those documents, only MAMC provided any form of reimbursable services; VAPSHCS provided none.

Within the agreement document however, there was a provision by which the VAPSHCS would provide the services of a Geriatric Fellowship Director. The reimbursement for this individual was based on 2/5 Full Time Equivalent (FTE), meaning that the director would be at MAMC for two full days of every week. Based on the director working at MAMC 40 percent of the time, MAMC would reimburse

VAPSHCS for 40 percent of the director's salary and benefits. Given the conflicting information between the sharing agreement and the summary spreadsheet of sharing activity, the researcher consulted with MAMC resource management (RMD) personnel to determine if MAMC was indeed paying VAPSHCS for the services described in the sharing agreement. The researcher determined that MAMC has paid for such services since 1989 and continues to pay for the services. However, MAMC RMD personnel could not verify if the director had actually worked two days each week at MAMC.

Further investigation led the researcher to MAMC's Adult Primary Care Clinic (APCC), where the director worked while at MAMC. The APCC staff verified that the fellowship director worked there, but indicated that she worked at MAMC for one morning, or a half-day each week, not two full days. She worked the remainder of the time at VAPSHCS facilities. The director stated that the original plan was for the fellowship director to spend 2 full days at MAMC, but that it never materialized. The current director has occupied the position since 1994 and cannot verify any activity prior to assuming the directorship.

Sharing documents from 1989 indicate that the service was a part of the agreement at that time, and that MAMC has paid for what appears to be 2 days of services per week at MAMC. Based on MAMC records of payment to VAPSHCS and on the comments of the current fellowship director, it appears that VAPSHCS over-billed MAMC between \$250,000 and \$500,000 for the fellowship director's services, depending on when the half-day at MAMC work schedule first started. Madigan's RMD staff is currently investigating to determine if MAMC was overcharged and if so, by how much. This particular service and its associated cost is now a part of the MAMC FY02

sharing summary worksheet and is also presented in the researcher's revised FY01 worksheet in Appendix B.

Another area of collaboration with the VA that MAMC is not tracking is that of pre-separation physical examinations. The reason for this is probably due to the fact that the arrangement is based on an agreement at the national level formed in 1997. Under this agreement, soldiers who are separating from the military who expect to file a claim for veteran's benefits receive a single physical examination that covers DOD's requirements for a physical exam as well as the VA's requirements. This streamlines the process for filing a claim and saves both the DOD and VA time, money and effort. It also spares exiting service members the hassle of two separate examinations, most likely in two separate, distant locations and a claims process that may span months. An explanation of the general process of obtaining the joint physical examination here at Fort Lewis follows.

The process is initiated at the Fort Lewis Consolidated Welcome/Out-processing Center in Waller Hall. One of the areas within Waller Hall the soldier must visit is the Veteran's Service Center. If after receiving a briefing at the service center, the soldier thinks he or she may be eligible to file a claim for veteran's benefits due to some service connected disability, Veterans Benefits Administration (VBA) staff assist the individual to determine if the service member is truly eligible. When VBA personnel have established that the service member is eligible, they instruct the service member to schedule the Part 1 portion of the physical examination at MAMC. When the results of the Part 1 portion of the exam are complete, the service member takes a copy of the results along with his or her medical record back to the Veteran's Service Center in Waller Hall. VBA

staff then schedule an appointment for Part 2 of the physical examination process at the VAPSHCS American Lake Campus. There are a few more steps involved, but the remaining steps are omitted, as they do not have an impact on the theme of this paper.

According to Ms. Mary Davis at the Veteran's Service Center, MAMC and the VAPSHCS conducted 384 exams during FY01. Madigan does not track the number of persons utilizing this service and therefore, does not track any associated cost avoidance.

This arrangement benefits the patient, MAMC, VAPSHCS, and the VBA. The patient benefits from the streamlined process, Madigan benefits by not having to perform Part 2 of the service members' separation physical exam, VAPSHCS benefits by not having to conduct Part 1 of the physical exam. The VBA benefits in that it is the organization responsible for all veterans' claims physical examinations, and MAMC is absorbing the costs associated with Part 1 of the examination. The streamlined process and decreased time frame for filing and approving a claim also benefit the VBA in the form of reduced workload and staff requirements. The MAMC Support Agreement Manager is currently staffing a draft version of a new agreement pertaining to this interaction. The researcher also presents FY01 data for number of exams performed and an associated cost avoidance figure of approximately \$76,000 for MAMC based on VAPSHCS performing Part 2 of the exam (see Appendix B).

Additional information the researcher provides in Appendix B includes a breakdown of the number of patients involved and number of services provided. The figures presented, though not 100% accurate, are conservative values. It is likely that the true values are larger, but they are not smaller than those presented.



Appendix B also displays data for the number residents/students trained via the various "bartered" sharing agreements, the length of each person's rotation, and the number of man hours spent at VAPSHCS facilities. The researcher also presents estimated dollar values for the time MAMC staff and residents give toward providing care to VAPSHCS patients during training rotations at VAPSHCS facilities.

Neither Madigan nor VAPSHCS are assimilating the necessary information to give the complete collaboration picture within a single office. Part of the reason for this is that there are more DOD/VA interactions occurring locally than just between MAMC and VAPSHCS. Other involved agencies include the Department of Veterans Affairs, the Veterans Benefits Administration, the Army Career and Alumni Program and various additional agencies. There are a lot of moving pieces, and unfortunately there is no policy or guidance in place delineating who collects the information, who reports the information to whom, which information should be collected, or assignment of data definitions in order to create the desired information. Either the Secretary level staffs of both Departments or the DOD/VA Executive Council need to come to agreement on a common system-wide reimbursement, tracking, and reporting methodology.

In the absence of such guidance however, MAMC needs to do what it can to improve its tracking and billing processes. Currently, active sharing agreements are tracked through a disconcerted effort on the part of various individuals in MAMC's Resource Management Division (RMD), Patient Administration Division (PAD), Department of Pathology, Pharmacy, Nutrition Care, and all other clinics that see VA patients. As indicated earlier, there is a wide disparity among the various clinics and departments regarding the degree of tracking VA patients. The current procedure by

which a VA patient obtains an appointment for care at MAMC and a bill for that care is generated follows.

A VA patient presents with a particular medical issue at VAPSHCS that is covered under the MAMC/VAPSHCS agreement. The VA provider contacts his or her counterpart at MAMC to arrange an appointment for the patient. The provider sends the patient to the VAPSHCS Fee Basis Section of the Medical Administration Service office at the American Lake Campus to pick up an authorization form. On the day of the appointment, the patient takes the authorization form and presents it to the front desk clerk of the clinic where the patient has an appointment. The clerk takes the form to an analyst in MAMC RMD, who is responsible for billing VAPSHCS. At the end of each month, the RMD analyst searches MAMC's data systems for all episodes of care for the particular patient. The analyst coordinates with personnel from the MAMC Patient Administration Department to generate a list of CPT codes for the patient's care. The analyst matches the codes with the prevailing CMAC rates and generates a bill. The analyst takes the bill to the Fee Basis Section at the American Lake Campus. American Lake Campus personnel review the episodes of care and verify the CPT codes. Often, they disagree with the codes and generate codes they feel are more appropriate. Once the coding issues are resolved, VPSHCS issues MAMC a check.

There are numerous issues with the process. First, MAMC staff may provide care to the patient other than what is "authorized." Sometimes VAPSHCS pays for the additional care, sometimes not. Second, a VA patient may present without an authorization form. The patient slips through the cracks. Third, the form may not find its way back to the analyst in RMD. Another issue with the process is that there is only one

person at VAPSHCS who processes the bills. Likewise there is only one person at MAMC who processes the bills. If either of these two individuals is gone for any reason, the entire tracking and billing process stops.

Based on observations made throughout the duration of this project, the researcher believes there are few new sharing opportunities available premised on one organization having a "need" of certain services and the other having a corresponding excess capacity of services. Both organizations operate in budget constrained environments and as such, are not staffed to levels that would afford either of them the luxury of having significant excess capacity. Minor opportunities will present themselves as staff levels in both organizations fluctuate, but again, most will be insignificant in the greater scheme of the organizations' delivery of health care.

What has not been explored yet however, are opportunities whereby both organizations are lacking something, whether that be a particular service, technology, capability, structural need, or item of equipment. This is one area that may pay greater dividends. An example could be that neither MAMC nor VAPSHCS have enough Optometrists to adequately service each of their individual beneficiary populations. The individual need of each facility may not justify the acquisition of an additional Optometrist. However, the combined need of the two organizations may be enough to warrant collaboration between the two, and enough to justify jointly hiring an Optometrist to serve the needs of both organizations.

Another, more daring approach, is for the two organizations to identify each of their respective strengths and weaknesses. Planning could center on possibly shifting various service line staff and the patient workload the staff would see to the location or

facility most capable of providing that care. Various task force teams have hinted at examples of this, but to date no agreements have developed. One example of this centers on the VAPSHCS American Lake Campus performing its procedures in MAMC's operating rooms and clinic procedure rooms. The nursing services team raised the possibility of incorporating the American Lake Campus medical surgical ward into MAMC. Moving the American Lake Campus' medical surgical inpatient assets and workload to MAMC would require reallocation of space within MAMC. One possible way to create this space could be to move MAMC's inpatient psychiatric ward to the American Lake Campus. These are just the ramblings of a madman, but perhaps bold moves such as these are not so farfetched after all.

The researcher now presents a compilation of the efforts made by local DOD/VA Sharing Task Force members during the period of September 2001 through March 2002. This will show that even though only two new proposals are at the implementation stage, task force members from both organizations have devoted a great deal of effort toward establishing new sharing agreements.

Please note that the task force is comprised of both individual facility level personnel and regional level personnel. Though the title of this project is DOD/VA Sharing at MAMC, and the predominant theme is sharing between MAMC and VAPSHCS, the researcher also presents regional efforts that directly affect MAMC and/or VAPSHCS.

### Medical Services

The broad area of Medical Services has shown the most progress, at least from a local perspective. This includes all surgical services and medicine services, but

excludes mental health services, population health, nursing, ancillary services, and administrative services.

The first new sharing initiative generated since forming the DOD/VA Sharing Task Force is almost ready to implement. The VAPSHCS recently drafted a Memorandum of Understanding (MOU), which in general, involves MAMC providers examining and treating VA otolaryngology patients. The main driver behind this initiative, which comes with a heavy dose of local politics, is Graduate Medical Education (GME). According to Dr. Vincent Eusterman, Chief of Otolaryngology and Head and Neck Surgery at MAMC, and VAPSHCS medical staff, the number of head and neck cancer patients is decreasing. Both organizations have Otolaryngology GME programs, VAPSHCS's through an affiliation with the University of Washington (UW); therefore both organizations have a vested interest in this shrinking population of patients.

Currently, if VAPSHCS determines that the patient should have surgery, the patient must travel to Seattle to have the surgery performed. According to VAPSHCS, there is a backlog of several weeks for this kind of surgery. If MAMC staff performed the procedure, surgical intervention would happen much sooner, and the patient and their family members would not have to travel as far as they would otherwise.

The agreement involves MAMC providing attending physicians and residents to staff an Otolaryngology clinic for a half-day on every Friday at the American Lake Campus. Dr. Eusterman estimates that the clinic will see 25-30 patients per week and plans to staff the clinic with one attending physician and one resident.

The agreement states "it is expected that patients encountered in the clinic will get their operative care at MAMC." Though not clearly stated, this implies that MAMC

providers will perform the procedures. The VAPSHCS adds qualifying remarks regarding the surgical candidates who MAMC can and cannot have to operate on. The VAPSHCS entered a disclaimer into the agreement that states, "exceptions...are those patients who are desired for participation in new or ongoing research studies," which has implications of "cherry-picking."

Based on the number of head and neck cases that the American Lake Campus sent to the Seattle Campus during FY01, Dr. Gordon Starkebaum, Chief of Staff for VAPSHCS estimates that of the patients MAMC physicians would see in the half-day clinic at American Lake, approximately 25 patients per year would require surgery. A business case analysis (BCA) for this initiative is shown in Appendix C. The BCA for the Otolaryngology initiative shows that MAMC would most likely lose money. According to the current sharing agreement, reimbursement is based on the type of bed the patient occupies and the length of stay in each of those types of beds. The per diem rate for intensive care unit (ICU) beds is \$1720 dollars per day. The rate for any bed other than an ICU bed is \$900 per day.

The calculations in the top half of the spreadsheet on page 80 in Appendix C are based on the average length of stay (ALOS) for the top ten Diagnosis Related groups (DRGs) obtained from the Army's Standard Inpatient Data Record (SIDR) via the All Regional Server (ARS) Bridge and on Dr. Eusterman's estimated one to two day length of stay in an ICU bed. The ALOS for the top 10 DRGs did not vary significantly from the ALOS for all Otolaryngology patients seen during FY01. The calculations with asterisks and in bold show the breakeven point for various combinations of length of stay in the two types of beds. The calculations presented on the lower portion of the spreadsheet

are based on Dr. Eusterman's estimate of total average length of stay from prior experience with VA patients. The researcher deemed the historical length of stay based on the DRGs to be the most accurate and used these values for input into the BCA.

A confounding factor in all this is the amount of time that MAMC can keep the VA patient within MAMC's walls. According to the draft agreement, MAMC personnel will transfer the patient to a VAPSHCS facility as soon as the patient can be transported. Given the reimbursement procedures under the current agreement, the financial incentive for VAPSHCS is to transport the patient as soon as possible. The financial incentive for MAMC is to keep the patient in a bed as long as possible.

Another, more significant factor to consider is what is right for the patient? This is sometimes overlooked. At the time MAMC and VAPSHCS started their renewed efforts at increasing sharing activity in late 2001, the wait for VA patients to obtain a clinic visit at VAPSHCS was 14 weeks. This sharing initiative will dramatically decrease this wait time if not eliminate it completely. Also, according to Dr. Eusterman, he is more likely to keep VA patients longer in MAMC, not for financial reasons, but for patient safety reasons. His justification for keeping VA patients in MAMC longer is due to previous experiences with transferring patients to VAPSHCS, which resulted in adverse outcomes for those patients. Current experience with reimbursement in these situations is such that if a VAPSHCS physician determines that the patient can be transferred to a VAPSHCS facility and for some reason is not, then VAPSHCS stops reimbursement. This issue of who determines when a patient can safely be transferred should be addressed prior to finalizing the agreement.

The current draft version of this agreement states that MAMC will be responsible for all costs associated with dual-eligible patients and the VA will pay for all "pure" VA patients. According to Dr. Starkebaum, approximately 25 percent of the patients VAPSHCS sees are dual-eligibles. The dual-eligibles are accessing the health care system through the VA, but having their needs satisfied by the VA sending them to MAMC. If the patients are beneficiaries of both systems, why are the costs and risks associated with these patients not equally divided between the two organizations?

One last issue regarding the financial aspects of this agreement is that MAMC will staff the outpatient clinic at American Lake free of charge. According to the agreements leading up to and including FY95-96, MAMC staff conducted otolaryngology clinics at American Lake, but was reimbursed for the time MAMC staff devoted to the clinic. According to the agreement for FY 95-96, VAPSHCS would pay MAMC \$22,308 per year to staff the clinic with a staff member and a resident at American Lake based on both persons being in the clinic two days per month. Providing a clinic for a half day per week as proposed in the pending agreement is approximately equivalent to two days per month. Otherwise, VAPSHCS reimbursed MAMC at the rate of \$72.09 per hour for ENT staff physician services and \$47.85 per hour for ENT resident physician services. Madigan Department of Human Resources personnel calculated that this would amount to approximately \$26,000 for the year given current salary levels. This amount, added with the projected negative earnings of \$37,000 for inpatient care, means that MAMC will lose a conservative \$63,000 per year. This amount is insignificant compared with MAMC's overall budget, but may be worth revisiting prior to implementation.



Madigan Army Medical Center benefits by getting additional head and neck cases to help sustain its Graduate Medical Education (GME) Program. Graduate Medical education is obviously very important, but MAMC's leadership must make a conscious and well-informed decision considering all the aspects and implications of this agreement before giving its consent. The VAPSHCS benefits by having a reduced head and neck surgical backlog, by MAMC performing the surgeries rather than civilian facility, by MAMC providing outpatient services for VA patients for free, by MAMC absorbing the total cost of care for all dual-eligible patients, and by allowing the VA providers who would otherwise come to the American Lake Campus from Seattle to be more productive at the Seattle facility. Patients benefit through reduced waiting time for diagnosis and surgery, and through reduced travel time and distance for both themselves and their family members. The increased access afforded the patient should also generate higher patient satisfaction (Griffith, 1999).

A second initiative that looks promising is in the area of Obstetric and Gynecology (OB/Gyn) services. Currently, a general internist who has an interest in women's health sees female patients at the American Lake Campus. The MAMC Department of OB/Gyn and VAPSHCS staffs are exploring the idea of having American Lake's female patients needing gynecological services sent to MAMC for care. A business case analysis for this proposal is presented in Appendix D. The BCA indicates that this is a viable proposal and that MAMC would benefit from its implementation. Colonel George McClure, Chief, MAMC Department of OB/Gyn, estimated that the initiative would bring two to five patients per week into MAMC for gynecology services. He also stated that the department could easily absorb that number of additional patients without displacing

any of Madigan's normal patients. Accompanying the BCA is a spreadsheet that shows the financial calculations (see page D-10) used to provide input into the BCA. All patients would require diagnosis, catheterization, some form of cystoscopy, and one of multiple outpatient procedures. This would occur during several visits. Calculations show minimum, maximum, and mean values for the associated February 2002 Champus Maximum Allowable Charge (CMAC) rates (TRICARE Management Activity, 2002). According to the current sharing agreement, these are the rates that VAPSHCS will use to reimburse MAMC for outpatient services. Additionally, 20 percent of the patients would require one of several inpatient surgeries. As previously noted, the VAPSHCS reimburses MAMC for inpatient services based on the type of bed occupied and the length of stay in each type of bed. Current inpatient reimbursement rates are \$1720 per day for occupying an ICU bed and \$900 per day for occupying any bed other than an ICU bed. Dr. McClure stated that these patients would normally require a three-day stay in an "other than ICU" or "normal" bed. Final totals for all included services, located at the bottom of the spreadsheet, are calculated using the mean CMAC rate for all codes associated with each group of required services. Mean values for the rates are used, as there is an equal likelihood that patients will present with each code. Final values for cost and reimbursement entered into the BCA are those for the minimum number of patients per week that Dr. McClure estimates his staff would see if the agreement was implemented. Benefits to MAMC include possible additional cases for Graduate Medical Education, a greater than 100% return on investment (ROI) seen within the first year, and it would help to maintain or even increase staff competency. The VAPSHCS will benefit by not having to send one of its providers to the American

Lake Campus from the Seattle Campus, which given the traffic in the Puget Sound area, could take the provider away from the normal care setting for an entire day. This in turn increases the productivity of that staff member. A potential injury or illness would be found at an earlier stage, thereby reducing the cost of treating the patient. The patient receives a higher quality of care and benefits by being seen for a problem as the problem arises rather than a few days or weeks later. Increased access to higher quality care will lead increased patient satisfaction, albeit, with VAPSHCS, but should give MAMC some positive press also.

A third area discussed, considered the possibility of VAPSHCS utilizing two of Madigan's operating rooms (ORs) for its procedural cases. The American Lake Campus had engineers inspect all of its buildings after a major earthquake in 2001 for structural damage and safety. During the inspection, the engineers discovered that the operating rooms were contaminated with mold and that some structural repairs were needed. The initial estimate for repairing and decontaminating the rooms came in at approximately \$500,000. This large expense prompted VAPSHCS to look at other possible alternatives to the repair and decontamination. Using Madigan's operating rooms was one of the alternatives VAPSHCS considered.

Madigan has 14 operating rooms, of which it uses at no more than twelve. With MAMC having two unutilized operating rooms and the American Lake Campus facing a \$500,000 price tag to get its ORs in usable shape again, the idea of VAPSHCS personnel operating on VA patients in Madigan's ORs seemed to have merit.

Upon further examination however, MAMC personnel found that only 25 percent of the American Lake Campus caseload would be complex enough that MAMC's staff

would perform the procedure in one of its operating rooms. For the remaining 75 percent of the cases, the complexity was such that MAMC staff would typically use clinic procedure rooms to perform the procedures rather than a full operating room.

The issue here was that the standard of care MAMC staff established for the use of its ORs included the presence of anesthesiology personnel. Most of VAPSHCS's procedures would not require an anesthesiology presence. MAMC staff suggested to VAPSHCS that it could facilitate American Lake Campus staff performing "clinic" procedures in its clinic procedure rooms as well as more extensive procedures, those requiring anesthesia staff, in MAMC's two unused operating rooms.

While the two organizations were discussing the details, VAPSHCS leadership discovered that it would cost only \$50,000 to restore the rooms so that they could be used as "procedure rooms" whereas they needed the \$500,000 to restore/renovate the rooms to full operating room status. The VAPSHCS opted to spend the \$50,000 to make its rooms suitable for use as procedure rooms and the initiative currently lies dormant.

Other services whose key staff members are in a dialog with their VAPSHCS counterparts include Ophthalmology, Optometry, and Vascular Surgery. Madigan's Ophthalmology Clinic is currently VAPSHCS's most actively used service, with 104 patients seen during FY01. Discussion is on going, but no new near-term sharing opportunities have developed.

### Nursing Services

The nursing departments from both organizations have formally met on three separate occasions to discuss sharing opportunities. Both departments are excited

about collaborating in order to provide better patient care in smarter ways. Outside of the quarterly Task Force meetings, this is the only group that keeps formal minutes of its discussions. Three themes have dominated the discussions at these meetings: staffing, education, and the possibility of integrating the American Lake Campus 15-bed medical/surgical ward into MAMC.

The first idea revolves around the shortage of nurses and the difficulty in recruiting them. The nurses are currently looking at conducting joint job fairs to recruit nurses into federal service. They are also exploring the legal and contractual implications of the VA hiring nursing staff under Title 38 authority and having that staff work at MAMC. MAMC in turn would reimburse VAPSHCS for the nursing services provided by VAPSHCS's staff. Though not done with nursing staff, MAMC and VAPSHCS had arrangements in the past for the provision of physician services and currently have an arrangement that provides MAMC with the services of a fellowship director.

The second theme is that of education. Each organization provides many different internal Continuing Medical Education (CME) courses and each also brings in external agencies for additional staff educational opportunities. MAMC Consolidated Education Department staff is providing VAPSHCS copies of its FY02 course schedules and is considering VAPSHCS nurse participation in its Critical Care Nursing and Operating Room Nursing and other courses. In addition, the VHA has extensive on-line educational resources and programs. The Chief of MAMC's Consolidated Education Department is working with VAPSHCS personnel in order to gain access to these resources for MAMC personnel. Both nursing departments are also looking at each

other's long-term educational needs and goals and are planning how they can accomplish them together.

The third and most significant item under discussion is the concept of moving the American Lake Campus medical/surgical ward to MAMC. According to Ms. Frankie Manning, Chief Nurse Executive for VAPSHCS, the ward is currently staffed with twelve Registered Nurses (RNs), six Licensed Practical Nurses (LPNs), and two clerks. The ward has enough staffing and physical capacity for fifteen beds. VAPSHCS initially communicated an average patient census of "about eight" for the ward. However, an e-mail dated March 13, 2002 from Ms. Manning indicated that the average daily census is eleven patients, three of which require monitored beds. Typical patients are those with congestive heart failure (CHF) and pneumonia and have an average acuity of 2.8 on a four point medical/surgical acuity scale. Approximately 30 percent of the patients are from nursing homes. The average length of stay (ALOS) is seven days.

Under the discussed proposal, the VA patients and staff would be fully integrated into MAMC. In other words, there would be no "carve-out" ward within MAMC staffed by VAPSHCS nurses to care for VA patients only. The VA staff would be distributed to three different wards within MAMC based on current staffing levels, staff experience levels, and physical bed capacity in MAMC's wards. For the most part, it would be transparent to the staff that they were treating a MAMC patient versus a VA patient, and likewise transparent to the patients as to whether a VA nurse or a MAMC nurse was treating them.

The team needs to address several issues, consult other stakeholders, and develop a detailed plan of action before implementation is possible. The first of which is that

given the architecture of how MAMC's wards are currently, physically laid out, there is no more physical capacity or actual space to provide for more monitored beds. That ward, Ward 2 South, has a 20 bed physical capacity and is currently staffed and operating 20 out of 20 beds. There currently exists no space on this ward to put either VAPSHCS's three monitored beds, the patients who would occupy them, or the staff to care for them.

The other two wards where VAPSHCS's patients and staff would go are Ward 6 North and Ward 7 North. Both of those wards are currently staffed and have operating beds near their physical capacities also. Given the current ward organization, MAMC could not absorb the American Lake medical/surgical ward staff or patients.

Colonel Nancy Hodge, MAMC's Chief of Clinical Nursing Services, suggested that one possible solution to the issue with space on Ward 6 North, would be to expand the capability of Ward 6 North into part of Ward 6 South, which consists of observation beds. The issue here would be that patients of two different acuity levels requiring two standards of care would occupy beds on within the same ward. Though a challenge, it is not insurmountable. That still leaves the issue with where to put the monitored beds. Though this would be a challenge to implement in the short-term, MAMC and VAPSHCS leadership could develop a solution through mid- to long-term joint strategic planning.

#### Pharmacy

According to Dr. David Tomich Chief, Pharmacoeconomics at MAMC, the two organizations pharmacy staff members have been meeting and conversing for "a long time." The two staffs worked together in trying get Fort Lewis chosen as the Army test

site for a joint DOD/VA Consolidated Mail Order Pharmacy (CMOP) pilot project, but lost out to Ft. Hood. They are currently exploring development of regional pharmacy contracts, MAMC's use of VAPSHCS clinical pharmacists, and the possibility of establishing a joint regional level contract for the use of the drug information database, MICROMEDEX, and other pharmacy technologies. Dr. Tomich said most of the high dollar value sharing collaboration is in the area of pharmaceutical contracts, and this is currently being done at the national DOD/VA level, so he does not anticipate much sharing in the form of local pharmaceutical contracts. He said that there are currently 53 existing joint contracts for drug products at the national level and another 23 contracts pending.

Madigan's pharmacy is however, currently developing an MOU with the VAPSHCS, for MAMC pharmacy staff to provide the American Lake Campus with Intravenous (IV) solution services after hours. Colonel Allen Almquist, MAMC's Chief of Pharmacy, indicated that American Lake's pharmacy does not stay open 24-hours a day. He said the pharmacy at American Lake pre-mixes IV solutions for the nursing staff to administer to the patients known to need special solutions sometime during the night. There are times however, that the American Lake facility receives patients during the night who end up needing a specially mixed IV solution.

The plan according to the MOU is for the staff at American Lake to fax the IV solution request to VAPSHCS's Seattle hospital. The Seattle hospital's pharmacy will verify the order and check their computer database for appropriateness and any drug interaction implications for the patient. After the Seattle facility's pharmacy has approved the request, they will fax the request to MAMC's pharmacy. Madigan



pharmacy personnel will prepare the solution and call the American Lake staff when it is ready to be picked up. American Lake staff will then call for a taxi to pick up the IV solution from MAMC and to deliver the solution to the American Lake staff. As the expected use of this service is at most one to two times per week, MAMC will not charge for the service, but will track utilization.

#### Laboratory

Madigan's Department of Pathology has maintained a working relationship with VAPSHCS for several years. Current laboratory services that MAMC provides the American Lake Campus include approximately 60 lab studies per year and various blood transfusion services. The latter of these two services comprises the bulk of the current activity. According to Marta Harshbarger, Supervisor, Transfusion Services at MAMC, during FY01 MAMC provided 224 units of red blood cells and 4 units of fresh frozen plasma. Madigan charges VAPSHCS \$60 for each unit of red blood cells and \$50 for each unit of fresh frozen plasma. She stated that the most likely supplier available to VAPSHCS charges \$87 per unit of red blood cells. In most circumstances the units of red blood cells also require typing and screening tests and tests for crossmatching. Madigan also provides these services to VAPSHCS at prices greatly below those provided by the local civilian blood center. Madigan charges a bundled price of \$19.98 for these tests on the first unit of blood and only the \$6.12 charge for crossmatching for additional units. These compare with civilian blood center prices ranging from \$45 to \$130 depending on the difficulty of finding the particular crossmatch. In light of these "bargain" prices, VAPSHCS is currently trying to expand this service to its Seattle hospital.

In reference to new initiatives, team members are examining the DOD contract MAMC is using for referral lab services to determine if VAPSHCS would also benefit by using the contract. Madigan Department of Pathology staff have also offered thin-prep cytology services to VAPSHCS; VAPSHCS personnel are currently evaluating the merits of this service.

According to Colonel James Hawkins, Chief of Pathology at MAMC, the largest inhibitor of progress in the area of laboratory services is inability to electronically transfer lab results. He feels that having this capability would greatly enhance the number of services his department could provide VAPSHCS.

#### Regional Contracts

Madigan is currently using the VA's Subsistence Federal Supply Schedule (FSS) Contract with Alliant Food Services to provide the majority of the food products that MAMC uses in its dining facility and food service operations. According to the FY01 sharing summary spreadsheet, the amount of this contract was just over \$1 million for that year. The Defense Supply Center Philadelphia (DSCP) tacks on a surcharge of 6.1% for these items, while the VA adds only a 0.5% surcharge to purchases through its system. For FY00 MAMC's cost avoidance for utilizing the VA contract totaled \$62,000 (Everett, May 16, 2001). Figures for FY01 were not available.

Regarding efforts toward developing new sharing agreements, Major Jonathon Branch, Chief, Western Regional Contracting Office, said that his office is currently working on a Blanket Purchase Agreement acquisition to provide office supplies for all Army MTF's within the Western Region and also for VAPSHCS. Additionally, the Regional Contracts Workgroup is reviewing more than 220 regional contracts. The

workgroup is identifying those contracts that the two organizations have that are for the same or similar items, determining which contracts present the best value for both organizations, and determining if the two organizations can create joint contracts to provide even more savings. Please note that regional entities are performing the majority of the work in this area, although both MAMC and VAPSHCS stand to benefit from this work.

### Mental Health

This is an additional area where regional level personnel are exerting the majority of the effort. Dr. Jack Miller, TRICARE Region 11 Chief of Mental Health, has met on several occasions with mental health staff from Seattle, Portland and American Lake VA hospitals. Topics of discussion include education through the use of the VA's closed circuit tele-graduate medical education program and the possibility of sharing residents that attend the University of Washington and the Western State Hospital. Dr. Miller is also examining the Portland VA hospital's mental health program and may duplicate it locally in an effort to enhance bed utilization and to share expertise in the areas of drug and alcohol abuse and depression. Region 11 currently has tele-psychiatry capabilities at five of its facilities, to include MAMC, and is exploring how to expand that service to VAPSHCS also (Havard, December 10, 2001).

### IM/IT

Madigan implemented the use of a new software program known as the Integrated Clinical Database (ICDB) in October 2001. This program extracts inpatient and outpatient data from the military's disparate data systems, the Composite Health Care System (CHCS) and Ambulatory Data System (ADS/KG-ADS), and deposits the data

into a centralized Oracle® database (Williams, 2001). Madigan uses the database program primarily as a population health tool for its primary care providers, giving them visibility of their individual panel of patients, and greatly facilitates their ability to actively managing the health care needs of their panel. For example, the program allows the providers to screen their panel for all those patients who are diabetic. Of those who are diabetic, the program will identify those patients who have not had a hemoglobin A1C test within prescribed timelines or whose values are out of tolerance. Another example is the provider can come to work in the morning and screen his or her panel of patients to determine if any sought care in the emergency room the night previous, if any of the patients were admitted into the hospital, or if any transferred out of MAMC to another facility. The program puts a great deal of useful information at the providers' fingertips. Lieutenant Colonel David Williams, Chief, TRICARE Region 11 Informatics Office is currently expanding this capability to other military treatment facilities in the region and has offered access to VAPSHCS as well. This would allow VAPSHCS providers to access information on those DOD patients they treat in their facilities, also, VA patients treated in DOD facilities within Region 11, providing for better coordinated care.

Madigan is also installing a new computer system called the Operating Room Management Application (ORMA), consisting of both hardware and software. This application will create a virtual operating room between MAMC and the Bremerton Naval Hospital. This will allow the operating room staff at both facilities to view each other's surgical schedule and will provide for "real-time" scheduling between the facilities. Other features of the application include peri-operative documentation, inventory management, and various executive level and utilization reports (Williams,

2001). Access to this system would allow the VA to view MAMC's operating room schedules and be able to schedule a patient for a surgical procedure if desired.

Also under discussion are the prospects of VAPSHCS using Region 11's tele-dermatology and tele-psychiatry capabilities. This would require providing selected VA facilities with an audio/video workstation to link them to MAMC. This would also serve to increase patient access to care and decrease patient travel time to medical facilities.

Region 11 is also currently phasing in a new software application called TRICARE On-line. Through this application, Region 11 facilities, clinics and providers will establish their own individual web pages; providing useful information about the individual facility, clinic, and provider to their respective patients. Clinics and providers will post a percentage of their routine and established (follow-up) appointments on the web pages, allowing the patient to schedule his or her own appointment at a time that is best for the patient. The region will initially provide appointments to primary care providers only, but is planning to expand this to specialty care providers in the future.

Region 11 informatics personnel are working with VAPSHCS to determine if VAPSHCS providers are receptive to this application. The application would allow VAPSHCS providers to create personal web pages. It would also allow VA patients to schedule appointments with MAMC providers and MAMC patients to schedule appointments with VAPSHCS providers. The web pages are password protected, therefore only those patients who would have an appointment with a particular VA provider or VA patient with an appointment with a particular MAMC provider would have access to that provider's web page. A perfect example of this would be for female VA

patients in need of an OB/Gyn appointment. The patient could log on to the MAMC OB/Gyn physician's web page and set up her own routine or follow-up appointment.

Region 11 and VAPSHCS informatics personnel are in the process of determining what, if any, VAPSHCS's functional requirements for each of the systems are. If the group determines that VAPSHCS staff want to use the systems and identifies the functional requirements, it can develop a plan on how to expand the capabilities of the systems to VAPSHCS facilities and providers.

### CONCLUSIONS AND RECOMMENDATIONS

In reference to DOD/VA sharing in general, officials at the highest levels, such as OSD(HA) and VHA, and at every level of command or hierarchy in between, should give clear vision, guidance, intent and expectations as to what they want their subordinate organizations to accomplish. The researcher believes that if these organizations are truly serious about trying to increase the level of collaboration, then staffs at all levels should conduct joint strategic planning sessions. The researcher indicated earlier that in the Puget Sound area, none of the organizations has a large excess capacity of any type. The organizations are not resourced, structured, or staffed to have large amounts of excess capacity that we can match with the other organization's corresponding need. The organizations need to look at other, more daring ways to increase sharing, and it is only through joint strategic planning that any significant gains will occur.

Additionally, leaders at the OSD(HA) and VHA level need to establish a policy requiring dual-eligible patients to enroll in either the VHA system or the MHS system. They need to educate these patients and the various veterans' organizations that this will not inhibit their access to care, rather, it will facilitate their access and more

importantly, provide them with coordinated care. Some of these dual-eligibles bounce back and forth between the two systems, often times seeking the exact same care. They need to understand that one system does not necessarily have visibility of what care the other has provided the patient. This can be fatal if the patient is given one medication through the VA system and receives another medication through the MHS system with no electronic check systematic check for drug interaction. This will also greatly enhance the ability to track and provide appropriate reimbursement.

The researcher recommends that the VISN 20 and TRICARE Region 11/WRMC leadership invite and even more importantly, *involve* one another in each other's strategic planning efforts. The researcher also recommends that VISN 20 and Region 11/WRMC form a jointly staffed sharing cell, in order to monitor, drive, and to especially facilitate ongoing and future efforts. This could be as little as one VA staff member sharing an office on MAMC's eighth floor with his or her equivalent regional staff member. Likewise, to facilitate the spirit of equity, the two could also share office space at VAPSHCS, most likely at the Seattle Campus on other days. This would give each sharing cell member better perspective and facilitate understanding the culture, processes, and nuances of each other's organizations, further enhancing the effectiveness of the cell.

With regard to MAMC's current agreements, MAMC's leadership should ensure that the appropriate staff members, mainly providers and clerks, receive education on the procedures for tracking, treating, and billing of VA patients. This will facilitate the collection of information for the increasing reporting requirements that MAMC faces.

As with all new ventures, MAMC's leadership should require a thorough analysis of proposed sharing agreements. Use of tools such as the BCA will formally identify the advantages, disadvantages, financial implications benefits, and impact on the organization.

MAMC staff should revisit the current reimbursement method, particularly in the case of in-patient procedures, where MAMC is not reimbursed based on the procedure, but on the number of days that the patient spend in a particular type of bed. In addition, the leadership of both organizations may want to address the overall scheme of reimbursement. Does it make sense to have all outpatient care based on the prevailing CMAC rate? Does the organization need a positive return on investment through the process or does it make more sense to reimburse based on what it costs each organization to provide those services? Given the current fiscal environment, the researcher believes that neither organization should give the services at a loss to the other. That is unless the loss is either so insignificant that it does not affect the organization's delivery of care to its own beneficiaries or that overall, it saves the government and ultimately the taxpayer money.

Regarding the first initiative that is attainable and near the point of implementation, the OB/Gyn Initiative, I recommend that the appropriate MAMC staff members formalize and commence execution of this sharing agreement as soon as possible. The project has an immediate positive rate of return on investment and is beneficial to MAMC, VAPSHCS, and the patients involved. This is a win-win-win situation.

With respect to the second of the two initiatives near implementation, the Otolaryngology Initiative, based on the BCA and other unsettled items in the draft MOU,



MAMC's leaders should forgo executing the provisions of this initiative until several items have been addressed to their satisfaction. In addition, the MAMC Command Group needs to be involved in the decision-making process with a formal business plan developed and briefed, as part of the required process that any other submitted business initiative would go through. If the initiative is approved after all of this, then MAMC staff should execute, but not before. To take this one step further, MAMC's Command Group should require that every DOD/VA sharing initiative is researched, analyzed and presented as part of a formalized submission process before granting approval and obligating funds for the initiative.

Based on the researcher's observations of efforts to increase sharing between MAMC and VAPSHCS since September 2001, this researcher can say that it is not as easy as it might outwardly appear. Remnants of past agreements and hostilities and current competing agendas still cloud efforts to truly make progress. Nevertheless, the organizations *are* making progress and there are many individuals within both organizations who are ready, willing, and even excited at the prospect of partnering/working with the other toward something better.

The researcher concludes this project with a couple of excerpts from two highly respected gentlemen who spoke to hundreds of federal sector health care administrators during the 2002 American college of HealthCare Executives Nation Congress in Chicago, Illinois to leave the reader with some food for thought. The first was Mr. Anthony Principi, the Secretary of the Department of Veterans Affairs. Secretary Principi, during his presentation March 21, 2002, said that "so much more can be done and should be done" with respect to DOD/VA Sharing, and that the two

organizations are essentially "caring for *one population*." The second is Dr. Jacob Lozada, Assistant Secretary for Resources and Administration within the Department of Veterans Affairs. During his speech on March 20, 2002 at the Army Baylor Alumni dinner, he recounted his confirmation process for the attendees. He said that during his confirmation process, Senator Rockefeller asked him what the difference is between a soldier and a veteran. His reply was "one day."

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Dod Facility	VA Facility	Sharing Agreement # (FRS) for each Sharing Agreement	Type Service Provided	MEPRS Code	Frequency of Service Provided	Dod \$s Paid to VA	Dod to VA Bartered Services in \$s	Dod to VA Owed \$s	Dod to VA \$s in Dispute	VA \$s Paid to Dod	VA to Dod Bartered Services in \$s	VA to Dod Owed \$s	VA to Dod \$s in Dispute
MAMC	VAPSHICS Seattle, WA	ICA663-9019	Inpatient: Regular Stays		35					NOTE: Total dollars billed are through July 2001			
			ICU	DIAA	24					\$0.00		\$45,000.00	
			ICU Support	FAAA	0					\$0.00		\$31,600.00	
			Outpatient:							\$0.00		\$0.00	
			Ambulance		0					\$0.00		\$0.00	
			Internal Medicine	BAAA	0					\$0.00		\$0.00	
			Cardiology	BACA	0					\$0.00		\$0.00	
			Neurology	BAKA	0					\$0.00		\$0.00	
			Oncology	BAMA	3					\$104.37		\$104.37	
			Radiation Therapy	BASA	8					\$1,294.15		\$1,294.15	
			General Surgery	BBAA	8					\$0.00		\$1,081.28	
			Ophthalmology	BIDA	104					\$24,272.34		\$24,272.34	
			ENT/BBFA	BBFA	8					\$1,165.29		\$1,165.29	
			Urology	BHAA	0					\$0.00		\$700.68	
			Emergency/BIAA	BHDA	2					\$0.00		\$0.00	
			Audiology	BLAA	0					\$0.00		\$0.00	
			Physical Therapy	DBAA	unk					\$6,649.77		\$14,813.72	
			Pathology	DCAA	unk					\$4,010.82		\$13,507.06	
			Radiology		unk					\$0.00		\$10,425.52	
			Same Day Surgery	DGAA	11					\$0.00		\$163,964.41	
			VA/SHICS Total:			\$0.00	\$0.00	\$0.00	\$0.00	\$10,660.59	\$0.00	\$0.00	\$0.00
MAMC	VA/SHICS ID		Pharmacy Total	DAAA		\$0.00							
MAMC	VADDDC Denver, CO		Audiology Delivery Agreement Total	BIDN	unk	\$67,991.60							
MAMC	VA Central Office,		Interagency Cross-Services Support Agreement; Prime Vendor Contract Total		unk	\$1,046,974.57							
MAMC	Washington DC												
MAMC	VAPSHICS Seattle, WA	MCHJ-025-96	LPN Students Training : GA		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-036-98	Emergency Response (NIDMS)		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-111-99	Nurse Anesthetist Training : GA		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-113-99	Internship in Occupant Therapy Training, GA		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-028-00	Family Practice Residents, Geriatrics Tmg, GA		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-029-00	Physical Medicine & Rehabilitation/Neurology Suetmg, GA		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-030-00	General Surgery Residency PCOT 4 Tmg, GA		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-031-00	Podiatry Residents Tmg, AF		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-032-00	Ophthalmic Residency Tmg, AF		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-033-00	Internal Medicine Residency Tmg, GA		N/A								
MAMC	VAPSHICS Seattle, WA	MCHJ-034-00	OB/GYN Geniatric Medicine Residency Tmg, GA		N/A								
MAMC	VAPSHICS 200Portland HHS	NWLA	Hillb Sves Partnership		N/A								
MAMC TOTAL						\$1,114,966.17	\$0.00	\$0.00	\$0.00	\$10,660.59	\$0.00	\$163,964.41	\$0.00



## Appendix B

### Revised FY01 Summary of Paid Services Between MAMC and VAPSHCS

[illegible]

## Appendix B

## Revised FY01 Summary of Paid Services Between MAMC and VAPSHCS

[illegible]

Appendix B  
Revised FY01 Summary of Bartered Services Between MAMC and VAPSHCS

DoD Facility	VA Facility	Sharing Agreement # (FRS) for each Sharing Agreement	Type Service Provided	# of Students Trained; Services Provided	Length of Rotation(s)	# of man hours	DoD to VA Value in \$s	VA to DoD Value in \$s	Total Value in \$s	Active ?	Expiration Date	Other Status
MAMC	VAPSHCS, Seattle, WA	MCHJ-025-96	LPN Students Training : GA	73 students	one 12 day per student	1350	\$9,087		\$9,087	Yes	N/A	New agreement pending format change
MAMC	VAPSHCS, Seattle, WA	MCHJ-036-98	Emergency Response (NDMS)	2 instructors	one 6 day per student					Yes	N/A	
MAMC	VAPSHCS, Seattle, WA	MCHJ-111-99	Nurse Anesthetist Training : GA	4	1 month each	640	\$10,352.00			Yes	N/A	New agreement pending format change
MAMC	VAPSHCS, Seattle, WA	MCHJ-113-99	Internship in Occupational Therapy Training: GA							No	N/A	New agreement pending format change
MAMC	VAPSHCS, Seattle, WA	MCHJ-028-00	Family Practice Residents, Geriatrics Trng: GA	5	15 days each	600	\$9,705.00			Yes	N/A	New agreement pending format change
MAMC	VAPSHCS, Seattle, WA	MCHJ-029-00	Physical Medicine & Rehabilitation/ Neurology SvcTrng: GA							No	N/A	New agreement pending format change
MAMC	VAPSHCS, Seattle, WA	MCHJ-030-00	General Surgery PGY 4 Trng: GA							No	N/A	New agreement pending format change
MAMC	VAPSHCS, Seattle, WA	MCHJ-031-00	Podiatry Residents Trng: AF	No MAMC residents participate. MAMC has an agreement with the VAPSHCS for the training of students from the California College of Podiatric Medicine (CCPM).								2 New agreements staffed 4/02/02
MAMC	VAPSHCS, Seattle, WA	MCHJ-032-00	Ophthalmic Residency Trng: AF	1 Instructor 2 Students	1 day per month	288	\$6,473.28	N/A		Yes	N/A	Updated version staffed 3/13/02
MAMC	VAPSHCS, Seattle, WA	MCHJ-033-00	Internal Medicine Residency Trng: GA	9	1 month each	1440	\$23,292.00	N/A		Yes	N/A	New agreement pending format change
MAMC	VAPSHCS, Seattle, WA	MCHJ-034-00	OB/GYN Geriatric Medicine Residency Trng: GA	4	12 days each	384	\$6,211.20	N/A		Yes	N/A	New agreement pending format change
MAMC	VAPSHCS, Seattle, WA	NWLA	Health Svcs Partnership							No	12/31/02	
MAMC	VAPSHCS, Seattle, WA	DoDNA MOA	Pre-separation physical examinations	384 exams			N/A	\$76,270.08		Yes	N/A	Final draft of new local agreement staffed 4/02/02
TOTAL				384 Exams		4702	\$65,120.48	\$76,270.08	\$141,390.56			
Total Value of Paid and Bartered Services									\$2,274,980			

**Appendix C**  
**Otolaryngology Business Case Analysis**

Base BCA Template 3.4 (BSC Rationalization)

**Cover Page - Balanced Scorecard Initiative**

<b>Initiative Name:</b>	MAMC/VAPSHCS Otolaryngology Sharing Agreement						
<b>Strategic Theme:</b>	Manage Direct and Network Healthcare						
<b>Strategic Objective:</b>	Manage the healthcare system to maximize MTF capabilities						
<b>Target:</b>	100% ROI						
<b>Initiative Description:</b>	Initiate a sharing agreement with VAPSHCS where MAMC physicians and residents conduct a half day Otolaryngology clinic at American Lake VA ; MAMC performs surgery on surgical candidates ID'd in clinic						
<b>Initiative POC Name/Phone/E-mail:</b>	MAJ Kevin Mulalley, 968-0155, kmulalley@nw.amedd.army.mil						
<b>Status (Select one by marking "X")</b>	Developing	Pending	X	Approved	Implemented		
<b>Interdependencies:</b>	N/A						

**Executive Summary**

<b>Initiative Name:</b> MAMC/VAPSHCS Otolaryngology Sharing Agreement								
<b>Non-Fiscal "Value" Summary</b>								
<b>Description of Benefits:</b> The largest benefit is giving ENT additional cases of a higher complexity to sustain its GME program; Sustains/improves staff competency; Improves care to patients via increased accessibility and shortened wait times for treatment/surgery; Decreases patient/family member travel distance; Reduces VAPSHCS surgical backlog; Increases patient satisfaction								
<b>Complexity Issues:</b> Issues for this initiative will revolve around patient transfer to VAPSHCS. MAMC providers may want to keep patients in MAMC longer than VAPSHCS wishes. This could lead to problems with reimbursement. VAPSHCS will need to communicate/market the change in service to its beneficiaries.								
<b>Interdependency Issues:</b> Assumes that DOAOS will have the appropriate staffing to support MAMC's normal caseload and this initiatives cases also. Need to consider prioritization of surgical cases.								
<b>Benefit Drivers:</b> The number, complexity and case mix of the VA patients seen; Appropriate reimbursement for services provided								
<b>Risks:</b> "Cherry picking" on the behalf of VAPSHCS and its GME program with the University of Washington. VAPSHCS may not reimburse us appropriately.								
<b>Performance Measures/Metrics:</b> Percent ROI; Increase in workload, Increase in number of VA patients seen; Increase in \$ amount of care provided based on VA reimbursement rates; For VAPSHCS: Cost-avoidance								
<b>Fiscal "Value" Summary</b>								
<b>Budget:</b>	FY2001	FY 2002	FY 2003	FY 2004	FY2005	FY2006	FY 2007	FY03-07
Investment/Change in Direct Care		111,691						0
Cost Avoidance-Savings/MCS Contract Impact		(74,670)						0
Net Value or Savings		37,021						
Pay-off (ROI) %	#DIV/0!	-33%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Note: Manually enter all out-year Direct and CHAMPUS costs/savings as they are developed and exhibited in Worksheet "Net Value". In most cases these numbers will remain the same, if uninflated and assuming that none of your assumptions change. Please leave these dollars in a non-inflated, constant dollar state. They will be inflated by ASCRM as part of the validation process, by the appropriate OMB inflator.

## Appendix C

Base BCA Template 3.4 (BSC Rationalization)  
 Surge a sharing agreement with VAPSHCS where MAMC physicians and residents conduct a half day Otolaryngology clinic at American Lake VA ; MAMC performs surgery on  
 surgical candidates ID'd in clinic  
 MAJ Kevin Mulalley, 968-0155, kmulalley@nw.amedd.army.mil

[illegible]

Base BCA Template 3.4 (BSC Rationalization)

## Narrative Assessment

The narrative assessment, serves as a needed preface to developing either a business case analysis or business plan. It provides the opportunity for commanders and their staffs to mentally "war game" the process prior to performing the more quantitative portions of the business case analysis. The format walks the user through initial identification of goals and objectives as well as encouraging thought on how "success" will actually be measured. It continues by asking a series of questions designed to allow for articulation of process design opportunities and the development of alternative operational solutions. The format provides the chance for the activity to describe the resource requirements identified for each initiative under consideration. Finally the format allows for identification and description of all supporting plans needed to develop and execute each initiative under consideration.

In answering each question, please keep your responses as short and concise as possible. This can be enhanced through the use of bullet responses. You will see notes indicating when bullet responses are not only appropriate, but required for standardization and side-by-side comparison.

### Business Initiative Narrative - For each initiative the business unit should explain:

Data entry in Yellow highlighted cells. Bulletize your key points whenever applicable.

#### A. Goals & Objectives:

1. Describe how your Initiative will support Balanced Scorecard objectives of the AMEDD/RMC/MEDCOM....Why is this initiative required?

*This initiative supports the WRMC's and MAMC's objective to "manage the healthcare system to maximize MTF capabilities." Capacity exists in Otolaryngology; this initiative will help increase both inpatient and outpatient workload*

2. What are the objectives of your initiatives?

*Increase the number of head and neck cases seen by Otolaryngology residents in support of GME requirements  
Increase the level of sharing activity with VAPSHCS  
To have a positive return on investment*

#### B. Measures of Success: (if you can't do this - you cannot have a business plan)

1. What are the measures of success? How do they align to the goals/objectives described above?

*Any additional number of head and neck cases available to our residents.  
An increase in the total number of patients seen, procedures done and \$ amount of funds transferred as compared to FY01  
A 100% or greater return on investment  
Increased specialty care provider case mix and workload*

2. How will you know when you've achieved these goals/objectives? (What is the Balanced Scorecard target?)

*The target is 100% ROI  
When VA patients have been seen, surgeries have been performed, without effecting access and care for DoD beneficiaries*

3. What are the specific benefits in terms of improving access, quality, service, cycle-time, cost and patient safety?

*Improves access for VA beneficiaries and dual-eligibles receiving care through the VA system  
Cost to the VA is less than if they would have to send the patients downtown*

4. Who are your primary and secondary stakeholders? What will "the solution" look like to the individual patient, provider, administrator, other stake holders?

*Primary stakeholders are VA patients and the staff and residents of the MAMC Otolaryngology GME Program  
Secondary stakeholders are the other patients in need of Otolaryngology services, RMD, DOAOS, DON  
The solution will be transparent to MAMC's other beneficiaries and staff; will give VA patients greater access, shorter wait times*

#### C. Identifying Process Design Opportunities:

1. How will the solutions you develop change business & clinical practices (standards of care)?

*Otolaryngology personnel will have to adhere to the procedures, documentation, and standard of care of VAPSHCS  
In addition to those of MAMC  
Business practices will remain the same*

2. How can current practices be modified to improve delivery of this capability?

*Through continued DoD/VA collaboration*



**D. Identifying "As Is" and Analysis of Alternatives:**

1. What are the ways you currently provide MTF services (capabilities) and what combination of people, process, and tools are employed in this endeavor?

VAPSHCS providers coordinate directly with MAMC providers for appointments.  
VAPSHCS issues their patients authorization statements for them to receive care at MAMC.  
The patient takes the authorization statement to the clinic. The patient receives care. The statement goes to RMD.  
RMD looks up the record and assigns a code. RMD sends a bill to VAPSHCS. VAPSHCS reviews the coding. VAPSHCS pays the bill.  
Patient takes MAMC documentation back to VAPSHCS. VAPSHCS inputs data into their Computerized Patient Record System (CPRS)

2. What are the constraints to the current ways of providing these services/capabilities?

Process is time consuming, laborious, but does not prevent the process from occurring

3. What alternative methods could be used to do the same thing, either as well or better?

If VAPSHCS had a CHCS terminal, they could enter a referral into the system, rather than coordinate it manually  
Billing process could go through third party collections office in PAD  
Common information system architecture

4. What are the constraint/limitations (process, culture, people, resources, bandwidth, money, etc) for each alternative.

Lack of a CHCS Terminal at the American Lake Campus  
Third party collections office not familiar with tracking and billing procedures for VA patients  
Cost prohibitive at a local level

**E. Identifying Preferred Solutions:**

1. Based on systematic, objective data, (if you don't have this you cannot have measures of success) what is the preferred solution or combination of people, processes, and tools to remedy the problem?

At this point in time, the preferred solution is that which uses the personnel, processes and tools already in place, with no additional financial burden on either MAMC or VAPSHCS.

2. What other variables need to be considered in deciding to implement this solution? Is there similar experience elsewhere (within DoD, civilian, academia, industry) where the solution to the problem was successfully used in similar settings?

Other examples are currently ongoing here at MAMC; this particular initiative is one that MAMC and the American Lake Campus were doing up until the consolidation of American Lake and Seattle VA facilities into what is now known as VAPSHCS  
Similar examples exist involving other MTFs and VA facilities, but every agreement is site specific and unique

3. Are there technology components to the preferred solution? What are they?

A common information technology infrastructure would greatly facilitate the process, but is not necessary.  
In the interest of minimizing costs, it is not part of the preferred solution.

4. Why is technology required? Is the technology a driver or enabler of the process?

Technology is not required. It would be considered an enabler.

**F. Economic Analysis/Containing Costs:**

1. List the "things" such as people, processes, and tools required for the preferred solution.

No additional personnel or processes are needed.  
Office space, exam rooms, equipment, supplies, and computers at the American Lake outpatient clinic are being provided by VAPSHCS  
An addendum to the current sharing contract which addresses this initiative is needed; it is currently in draft form

2. Are other "partnering" alternatives viable and available (either as direct on-site service providers, resource shares, remote consultants, or tele-health consultants, other MACOMs or Services, etc) If so, with whom?

This is the other partnering alternative.

3. How can these help reduce practice variabilities (best practices) and contain costs?

N/A

<p>4. Describe the potential benefits and savings (e.g. saves staff time, money, other resources, decreased length of stay, improved data quality, etc.). When are benefits and savings realized?</p> <p>Decreased cost for VAPSHCS; decrease in VAPSHCS surgical backlog Decreased travel time for VA patients and family members; decreased time for appointment/surgery; increased patient satisfaction Increased case mix, workload for MAMC Otolaryngology staff/GME program</p>
<p><b>G. Clinical And/Or Intangible Improvements :</b></p> <p>1. Briefly summarize the clinical benefits to implementing this initiative.</p> <p>Helps maintain/increase Otolaryngology staff competency</p>
<p>2. What process or action can be used to "bridge the gap" between current performance and desired results?</p> <p>N/A</p>
<p><b>H. Overcoming Constraints:</b></p> <p>1. Review the constraints identified in question "D.2." above. Are there additional barriers/limitations not covered? Alibis?</p> <p>N/A</p>
<p>2. Identify the risks for each constraint.</p> <p>Personnel involved in the tracking and billing processes perform these processes as additional duties. Significant increases in sharing activity may increase the amount of time to perform these processes and eventually require someone to do them full-time. The amount of additional work for these individuals created by this initiative will not cause this to happen.</p>
<p>3. Can any of the partnering options identified help overcome any of the constraints?</p> <p>Short of creating a joint VISN 20/Region 11/WRMC "sharing cell", no.</p>
<p>4. For each constraints, who needs to be engaged to overcome this constraint? (example: RMC/MSC, MEDCOM, ASD(HA), Legislative change, etc)</p> <p>VISN 20, WRMC, TRICARE Region 11</p>
<p><b>I. Deployment Plan:</b></p> <p>1. What is the recommended deployment strategy? Consider:</p> <ul style="list-style-type: none"> <li>a. Program management structure &amp; implementation (Department, Division, or POC)</li> <li>b. Training plan (if applicable)</li> <li>c. Communications/marketing plan</li> <li>d. Procurement plan (personnel, equipment, facilities)</li> <li>e. Technology implementation, testing, and integration plan</li> <li>f. Metrics plan: Balanced Scorecard integration between objective-measure-target and your initiative (cause and effect)</li> </ul> <p>Program will be managed/implemented by MAMC Otolaryngology and VAPSHCS Otolaryngology staff MAMC DCCS and VAPSHCS Chief Medical Officer will monitor VAPSHCS staff will communicate the program to their beneficiaries Personnel, equipment, facilities already exist MAMC RMD will monitor the ROI, number of patients seen, procedures performed, funds exchanged MAMC Otolaryngology will monitor the number and case mix of patients seen for GME and competency purposes</p>
<p>2. What is the long term life-cycle management plan or projected time frames for changes the standards of care plan for this initiative?</p> <p>The initiative will be reviewed after 6 months; every year thereafter.</p>



**Appendix C**  
**Otolaryngology Business Case Analysis**

**DOD/VA Sharing 76**

*Base BCA Template 3.4 (BSC Rationalization)*

*Initiate a sharing agreement with VAPSHCS where MAMC physicians and residents conduct a half day Otolaryngology clinic at American Lake VA ; MAMC performs surgery on surgical candidates ID'd in clinic  
 MAJ Kevin Mulalley, 968-0155, kmulalley@nw.amedd.army.mil*

**Unfunded Requirements**

	Current Funding	Initiative Requirement	Second Year Phase-In	Third Year Phase-In
<b><u>Investment</u></b>				
Marginal		(111,691)		
TPC		74,670		
Capital				
Labor				
Travel				
Resource Support/Local Contract				
Supplemental Care				
Miscellaneous				
<b>Direct Care Net or Net Investment</b>	<b>\$ -</b>	<b>\$ (37,021)</b>	<b>\$ -</b>	<b>\$ -</b>
<b><u>Savings/Cost Avoidance</u></b>				
Change in Direct Care: Savings (+) / Cost (-)				
MCS Contract Impact: Savings (+) / Cost (-)				
<b>*Net Value</b>	<b>\$ -</b>	<b>\$ (37,021)</b>	<b>\$ -</b>	<b>\$ -</b>

Base BCA Template 3.4 (BSC Rationalization)

Initiate a sharing agreement with VAPSHCS where MAMC physicians and residents conduct a half day Otolaryngology clinic at American Lake VA ; MAMC performs surgery on surgical candidates ID'd in clinic  
MAJ Kevin Mulalley, 968-0155, kmulalley@nw.amedd.army.mil

### Rationalization and Prioritization Criteria

#### Screening Criteria

1. Discretionary or Non-discretionary

#### Evaluation Criteria

2. Strategic focus and relevance
3. Financials:
  - Cost
  - Resource availability
  - Profit impact
  - Time to results
4. Complexity to implement
  - Interdependencies
  - Human resource requirements
  - Sponsorship and readiness to change
5. Capabilities building potential
  - Models future capabilities
  - Time to impact

Instructions: The following sections assist you in the rationalization and prioritization of your initiatives using a standard AMEDD Balanced Score Card methodology. Please complete the following questions, then use the grading guidelines to score your initiative in accordance with the standardized criteria. Enter this score in the appropriate green box for each evaluation criteria.

Criteria	Grade of Factors	Scoring System				
Screening Criteria						
<b>1. Discretionary or Non-discretionary</b>						
- Non-discretionary - initiatives which, if stopped, would cause business operations to be severely hampered or even cease (e.g. Y2K). Enter "2" points for non-discretionary initiatives.						
- Discretionary - all other initiatives. Enter only one point for discretionary initiatives.	1					
	Score					
Enter score here →	1					

Evaluation Criteria	Grade of Factors	High / High	Med/High High/Med	Med/Med High/Low	Low/Med Med/Low Low/High	Low/Low
<b>2. Strategic Focus &amp; Relevance</b>	Grade	4	3	2	1	0
<b>2.1 Strategic Focus</b>						
High Significantly impacts 5 or more of the strategic obj.						
Medium Directly impacts 3 to 7 of the strategic objectives						
Low Impacts less than 3 strategic objectives	X					
<b>2.2 Time to Results</b>						
High Delivered within 1 year	X					
Medium Delivered within 2 years						
Low Delivered in > 2 years						
	Score					
	1					

Evaluation Criteria		Grade of Factors	High / High	Med/High High/Med	Med/Med High/Low	Low/Med Med/Low Low/High	Low/Low
3. Financials (2 of 4)		Grade	4	3	2	1	0
<b>3.1 Financial Resource Availability</b>							
High	Requires no incremental funding	X					
Medium	Requires incremental funding or significant budget reallocation, < \$250k annually						
Low	Requires major infusion of funds, more than \$250k annually						
<b>3.2 Reallocation Complexity</b>							
High	Not required or highly doable without significant risk	X					
Medium	Doable with moderate impact of negative performance impact						
Low	Not doable or incurs significant risk of performance impact						
		Score					
		3					

Evaluation Criteria		Grade of Factors	High / High	Med/High High/Med	Med/Med High/Low	Low/Med Med/Low Low/High	Low/Low
3. Financials (4 of 4)		Grade	4	3	2	1	0
<b>3.3 Profit Impact over 3 years</b>							
High	+\$500 k	X					
Medium	\$200k+ and < \$500k						
Low	< \$200						
<b>3.4 Timeframe</b>							
High	75% of profit impact achieved in < 1 year	X					
Medium	75% of profit impact achieved in < 2 years						
Low	75% of profit impact achieved in > 2 years						
		Score					
		0					

Evaluation Criteria		Grade of Factors	High / High	Med/High High/Med	Med/Med High/Low	Low/Med Med/Low Low/High	Low/Low
4. Complexity to Implement		Grade	2	1.5	1	0.5	0
4.1. Interdependencies		Score					
High	With proper governance and execution, the initiative can succeed in its own right						
Medium	Interdependence with other initiatives is significant, but manageable	X					
Low	Requires output and success of multiple other initiatives to succeed						
4.2. Human Resource Requirements							
High	Can be accomplished with existing people and skills	X					
Medium	Requires the investment of high-leverage outside resources in the short term						
Low	Requires a major, long-term investment in outside resources						
		Score					
		1.5					

Evaluation Criteria		Grade of Factors	All Four Boxes Checked	Any Three Boxes Checked	Any Two Boxes Checked	Any One Box Checked	No Boxes Checked
		Grade	2	1.5	1	0.5	0
4.3 Quality of Sponsorship							
5	Sponsor engaged	X					
5	Sponsor Accountable	X					
5	Project Manager in Place	X					
5	Critical mass of people aware & ready to participate	X					
		Score					
		2					

Evaluation Criteria		Grade of Factors	High / High	Med/High High/Med	Med/Med High/Low	Low/Med Med/Low Low/High	Low/Low
5. Capabilities-Building Potential		Grade	4	3	2	1	0
5.1 Models Future Capabilities							
High	Builds highly needed strategic capabilities or required for future success						
Medium	Builds lower priority capabilities that will be required for future success	X					
Low	Has little impact on building strategic capabilities						
5.2 Time to Impact							
High	The capabilities developed will have performance impact in FY01	X					
Medium	The capabilities developed will have performance impact within 2 years						
Low	The capabilities developed will have little impact in the next 2 years						
		Score					
		3					

## Appendix C Otolaryngology Calculations

### MAMC/VAPSHCS Otolaryngology Sharing Agreement Calculations

Surgeries per year	Surgeries Reimbursed	ALOS ICU	ICU Per Diem Rate	ALOS Other than ICU	Other than ICU Per Diem Rate	Reimbursement per Inpatient Procedure	Total Yearly Reimbursement	Marginal Cost/visit	Total cost per year	Yearly Return on Investment	Percent ROI
Otolaryngology FY01 ALOS of 2.84 days; Source - Standard Inpatient Data Repository (SIDR) via the ARS Bridge											
***25	19	0.0	\$ 1,720	6.5	\$ 900	\$ 5,886	\$ 111,834	\$ 4,468	\$ 111,691	\$ 143	100%
25	19	1.0	\$ 1,720	2.0	\$ 900	\$ 3,520	\$ 66,880	\$ 4,468	\$ 111,691	\$ (44,811)	60%
***25	19	1.0	\$ 1,720	4.6	\$ 900	\$ 5,887	\$ 111,853	\$ 4,468	\$ 111,691	\$ 162	100%
25	19	1.5	\$ 1,720	1.5	\$ 900	\$ 3,930	\$ 74,670	\$ 4,468	\$ 111,691	\$ (37,021)	67%
***25	19	1.5	\$ 1,720	3.7	\$ 900	\$ 5,883	\$ 111,777	\$ 4,468	\$ 111,691	\$ 86	100%
25	19	2.0	\$ 1,720	1.0	\$ 900	\$ 4,340	\$ 82,460	\$ 4,468	\$ 111,691	\$ (29,231)	74%
***25	19	2.0	\$ 1,720	2.7	\$ 900	\$ 5,879	\$ 111,701	\$ 4,468	\$ 111,691	\$ 10	100%
***25	19	2.5	\$ 1,720	1.8	\$ 900	\$ 5,884	\$ 111,796	\$ 4,468	\$ 111,691	\$ 105	100%
*** Indicates breakeven combinations											

Length of Stay based on MAMC Chief, Otolaryngology Experience with VA patients; 1-2 days ICU, 4 days Other											
25	19	1	\$ 1,720	4	\$ 900	\$ 5,320.00	\$ 101,080	\$ 4,468	\$ 111,691	\$ (10,611)	90%
25	19	1.5	\$ 1,720	4	\$ 900	\$ 6,180.00	\$ 117,420	\$ 4,468	\$ 111,691	\$ 5,729	105%
25	19	2	\$ 1,720	4	\$ 900	\$ 7,040.00	\$ 133,760	\$ 4,468	\$ 111,691	\$ 22,069	120%

Note: These figures assume that the patient will be a MAMC inpatient for the identified lengths of stay. This is one point of contention that has not yet been agreed upon between MAMC Chief, Otolaryngology and VAPSHCS. It is VAPSHCS's intention to have the patient transferred to a VAPSHCS as soon as the patient is able to be transferred, for obvious fiscal reasons. Due to previous adverse outcomes for patients who were transferred to VAPSHCS, the Chief of MAMC Otolaryngology wants to keep the patients at MAMC for as long as he deems necessary for the safety of the patient.

**Appendix D**  
**OB/Gyn Business Case Analysis**

Base BCA Template 3.4 (BSC Rationalization)

**Cover Page - Balanced Scorecard Initiative**

<b>Initiative Name:</b>	MAMC/VAPSHCS OB/Gyn Sharing Agreement						
<b>Strategic Theme:</b>	Manage Direct and Network Healthcare						
<b>Strategic Objective:</b>	Manage the healthcare system to maximize MTF capabilities						
<b>Target:</b>	100% ROI						
<b>Initiative Description:</b>	Initiate a sharing agreement with VAPSHCS whereby VA American Lake OB/Gyn patients are seen and treated by MAMC OB/Gyn physicians and residents in MAMC.						
<b>Initiative POC Name/Phone/E-mail:</b>	MAJ Kevin Mulalley, 968-0155, kmulalley@nw.amedd.army.mil						
<b>Status (Select one by marking "X")</b>	Developing	X	Pending		Approved		Implemented
<b>Interdependencies:</b>	N/A						

**Executive Summary**

**Initiative Name:**  
MAMC/VAPSHCS OB/Gyn Sharing Agreement

**Non-Fiscal "Value" Summary**

<b>Description of Benefits:</b>
High rate of return on investment; Payback occurs as soon as the bill is processed; Increased workload and case mix for staff and residents; Supports OB/Gyn GME Program; Sustains staff competency; Can be supported with existing resources; Better care for VA patients; Patients have less travel distance/time
<b>Complexity Issues:</b>
Needs coordination between MAMC OB/Gyn and VAPSHCS; Need to develop an addendum to the current sharing agreement; VAPSHCS needs to communicate/market the change in service to its patients
<b>Interdependency Issues:</b>
N/A
<b>Benefit Drivers:</b>
Ability of MAMC OB/Gyn to absorb the increased patient visits; The number of VA patients that are seen; Accuracy and timeliness of the coding and billing procedures
<b>Risks:</b>
Financially, none, unless VAPSHCS does not appropriately reimburse. If this is the case, we can terminate the agreement.
<b>Performance Measures/Metrics:</b>
Percent ROI; Increase in workload, Increase in number of VA patients seen; Increase in \$ amount of care provided based on VA reimbursement rates; For VAPSHCS: Cost-avoidance

**Fiscal "Value" Summary**

Budget:	FY2001	FY 2002	FY 2003	FY 2004	FY2005	FY2006	FY 2007	FY03-07
Investment/Change in Direct Care		39,370						0
Cost Avoidance-Savings/MCS Contract Impact		(151,341)						0
Net Value or Savings	-	(111,971)	-	-	-	-	-	-
Pay-off (ROI) %	#DIV/0!	284%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Note: Manually enter all out-year Direct and CHAMPUS costs/savings as they are developed and exhibited in Worksheet "Net Value". In most cases these numbers will remain the same, if uninflated and assuming that none of your assumptions change. Please leave these dollars in a non-inflated, constant dollar state. They will be inflated by ASCRM as part of the validation process, by the appropriate OMB inflator.

## Decision Matrix

[illegible]

Base BCA Template 3.4 (BSC Rationalization)

## Narrative Assessment

The narrative assessment, serves as a needed preface to developing either a business case analysis or business plan. It provides the opportunity for commanders and their staffs to mentally "war game" the process prior to performing the more quantitative portions of the business case analysis. The format walks the user through initial identification of goals and objectives as well as encouraging thought on how "success" will actually be measured. It continues by asking a series of questions designed to allow for articulation of process design opportunities and the development of alternative operational solutions. The format provides the chance for the activity to describe the resource requirements identified for each initiative under consideration. Finally the format allows for identification and description of all supporting plans needed to develop and execute each initiative under consideration.

In answering each question, please keep your responses as short and concise as possible. This can be enhanced through the use of bullet responses. You will see notes indicating when bullet responses are not only appropriate, but required for standardization and side-by-side comparison.

### Business Initiative Narrative - For each initiative the business unit should explain:

Data entry in Yellow highlighted cells: Bulletize your key points whenever applicable.

#### A. Goals & Objectives:

1. Describe how your Initiative will support Balanced Scorecard objectives of the AMEDD/RMC/MEDCOM....Why is this Initiative required?

*This Initiative supports the WRMC's and MAMC's objective to "manage the healthcare system to maximize MTF capabilities." Capacity exists in OB/Gyn; this Initiative will help increase case mix and outpatient workload*

2. What are the objectives of your Initiatives?

*Increase the number and complexity of Gynecology cases seen by OB/Gyn residents in support of GME requirements  
Increase the level of sharing activity with VAPSHCS  
To have a positive return on investment  
Provide increased quality of care for VAPSHCS American Lake OB/Gyn patients*

#### B. Measures of Success: (If you can't do this - you cannot have a business plan)

1. What are the measures of success? How do they align to the goals/objectives described above?

*An increase in the total number of patients seen, procedures done and \$ amount of funds transferred as compared to FY01  
A 100% or greater return on investment  
Increased specialty care provider case mix and workload*

2. How will you know when you've achieved these goals/objectives? (What is the Balanced Scorecard target?)

*The target is 100% ROI  
When VA patients have been seen, procedures have been performed, without effecting access and care for DoD beneficiaries*

3. What are the specific benefits in terms of improving access, quality, service, cycle-time, cost and patient safety?

*Improves access for VA beneficiaries and dual-eligibles receiving care through the VA system  
Cost to the VA is less than if they would have to send the patients downtown  
OB/Gyn care and treatment is more timely and appropriate*

4. Who are your primary and secondary stakeholders? What will "the solution" look like to the individual patient, provider, administrator, other stake holders?

*Primary stakeholders are VA patients and the staff and residents of the MAMC OB/Gyn GME Program  
Secondary stakeholders are the other patients in need of OB/Gyn services, RMD, Out-Patient Records  
The solution will be transparent to MAMC's other beneficiaries and staff; will give VA patients greater access, shorter wait times, more appropriate care*

#### C. Identifying Process Design Opportunities:

1. How will the solutions you develop change business & clinical practices (standards of care)?

*Standard of care will remain unchanged  
Business and clinical practices will remain the same*

2. How can current practices be modified to improve delivery of this capability?

*Through continued DoD/VA collaboration*



**D. Identifying "As Is" and Analysis of Alternatives:**

1. What are the ways you currently provide MTF services (capabilities) and what combination of people, process, and tools are employed in this endeavor?

VAPSHCS providers coordinate directly with MAMC providers for appointments.  
VAPSHCS issues their patients authorization statements for them to receive care at MAMC.  
The patient takes the authorization statement to the clinic. The patient receives care. The statement goes to RMD.  
RMD looks up the record and assigns a code. RMD sends a bill to VAPSHCS. VAPSHCS reviews the coding. VAPSHCS pays the bill.  
MAMC Outpatient Records sends documentation to VAPSHCS. VAPSHCS also sends monthly utilization log for verification.

2. What are the constraints to the current ways of providing these services/capabilities?

Process is time consuming, laborious, but does not prevent the process from occurring

3. What alternative methods could be used to do the same thing, either as well or better?

If VAPSHCS had a CHCS terminal, they could enter a referral into the system, rather than coordinate it manually  
Billing process could go through third party collections office in PAD  
Common information system architecture

4. What are the constraint/limitations (process, culture, people, resources, bandwidth, money, etc) for each alternative.

Lack of a CHCS Terminal at the American Lake Campus  
Third party collections office not familiar with tracking and billing procedures for VA patients  
Cost prohibitive at a local level

**E. Identifying Preferred Solutions:**

1. Based on systematic, objective data, (if you don't have this you cannot have measures of success) what is the preferred solution or combination of people, processes, and tools to remedy the problem?

At this point in time, the preferred solution is that which uses the personnel, processes and tools already in place, with no additional financial burden on either MAMC or VAPSHCS.

2. What other variables need to be considered in deciding to implement this solution? Is there similar experience elsewhere (within DoD, civilian, academia, industry) where the solution to the problem was successfully used in similar settings?

Other examples are currently ongoing here at MAMC; this particular initiative is one that MAMC and the American Lake Campus were doing up until the consolidation of American Lake and Seattle VA facilities into what is now known as VAPSHCS  
Similar examples exist involving other MTFs and VA facilities, but every agreement is site specific and unique

3. Are there technology components to the preferred solution? What are they?

A common information technology infrastructure would greatly facilitate the process, but is not necessary.  
In the interest of minimizing costs, it is not part of the preferred solution.

4. Why is technology required? Is the technology a driver or enabler of the process?

Technology is not required. It would be considered an enabler.

**F. Economic Analysis/Containing Costs:**

1. List the "things" such as people, processes, and tools required for the preferred solution.

No additional personnel or processes are needed.  
An addendum to the current sharing contract which addresses this initiative is needed

2. Are other "partnering" alternatives viable and available (either as direct on-site service providers, resource shares, remote consultants, or tele-health consultants, other MACOMs or Services, etc) If so, with whom?

This is the other partnering alternative.

3. How can these help reduce practice variabilities (best practices) and contain costs?

N/A

<p>4. Describe the potential benefits and savings (e.g. saves staff time, money, other resources, decreased length of stay, improved data quality, etc.). When are benefits and savings realized?</p> <p>Decreased cost for VAPSHCS; Eliminates need for Seattle Campus to send provider to American Lake; Increases VAPSHCS provider productivity. Decreased travel time for VA patients and family members; decreased time for appointment; increased patient satisfaction. Increased case mix, workload for MAMC OB/Gyn staff/GME program. More appropriate care for VA OB/Gyn patients</p>
<p><b>G. Clinical And/Or Intangible Improvements :</b></p>
<p>1. Briefly summarize the clinical benefits to implementing this initiative.</p> <p>Helps maintain/increase OB/Gyn staff competency</p>
<p>2. What process or action can be used to "bridge the gap" between current performance and desired results?</p> <p>N/A</p>
<p><b>H. Overcoming Constraints:</b></p>
<p>1. Review the constraints identified in question "D.2." above. Are there additional barriers/limitations not covered? Alibis?</p> <p>N/A</p>
<p>2. Identify the risks for each constraint.</p> <p>Personnel involved in the tracking and billing processes perform these processes as additional duties, typically after hours. Significant increases in sharing activity may increase the amount of time to perform these processes and eventually require someone to do them full-time. The amount of additional work for these individuals created by this initiative will not cause this to happen.</p>
<p>3. Can any of the partnering options identified help overcome any of the constraints?</p> <p>Short of creating a joint VISN 20/Region 11/WRMC "sharing cell", no.</p>
<p>4. For each constraints, who needs to be engaged to overcome this constraint? (example: RMC/MSD, MEDCOM, ASD(HA), Legislative change, etc)</p> <p>VISN 20, WRMC, TRICARE Region 11</p>
<p><b>I. Deployment Plan:</b></p>
<p>1. What is the recommended deployment strategy? Consider:</p> <ul style="list-style-type: none"> <li>a. Program management structure &amp; Implementation (Department, Division, or POC)</li> <li>b. Training plan (if applicable)</li> <li>c. Communications/marketing plan</li> <li>d. Procurement plan (personnel, equipment, facilities)</li> <li>e. Technology implementation, testing, and integration plan</li> <li>f. Metrics plan: Balanced Scorecard integration between objective-measure-target and your initiative (cause and effect)</li> </ul> <p>Program will be managed/implemented by MAMC OB/Gyn and VAPSHCS OB/Gyn staff MAMC DCCS and VAPSHCS Chief Medical Officer will monitor VAPSHCS staff will communicate the program to their beneficiaries Personnel, equipment, facilities already exist MAMC RMD will monitor the ROI, number of visits, procedures performed, funds exchanged MAMC OB/Gyn will monitor the number and case mix of patients seen for GME and competency purposes</p>
<p>2. What is the long term life-cycle management plan or projected time frames for changes the standards of care plan for this initiative?</p> <p>The initiative will be reviewed after 6 months; every year thereafter.</p>

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Initiate a sharing agreement with VAPSHCS whereby VA American Lake OB/Gyn patients are seen and treated by MAMC OB/Gyn physicians and residents in MAMC.

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**Unfunded Requirements**

Based on avg of 3.5 pts/week		Current Funding	Initiative Requirement	Second Year Phase-In	Third Year Phase-In
<u>Investment</u>					
	Marginal		(68,897)		
	TPC		264,846		
	Capital				
	Labor				
	Travel				
	Resource Support/Local Contract				
	Supplemental Care				
	Miscellaneous				
Direct Care Net or Net Investment		\$ -	\$ 195,949	\$ -	\$ -
<u>Savings/Cost Avoidance</u>					
Change in Direct Care:		Savings (+) / Cost (-)			
MCS Contract Impact:		Savings (+) / Cost (-)			
*Net Value		\$ -	\$ 195,949	\$ -	\$ -

Based on min of 2 pts/week		Current Funding	Initiative Requirement	Second Year Phase-In	Third Year Phase-In
<u>Investment</u>					
	Marginal		(39,370)		
	TPC		151,341		
	Capital				
	Labor				
	Travel				
	Resource Support/Local Contract				
	Supplemental Care				
	Miscellaneous				
Direct Care Net or Net Investment		\$ -	\$ 111,971	\$ -	\$ -
<u>Savings/Cost Avoidance</u>					
Change in Direct Care:		Savings (+) / Cost (-)			
MCS Contract Impact:		Savings (+) / Cost (-)			
*Net Value		\$ -	\$ 111,971	\$ -	\$ -

Based on max 5 pts/week		Current Funding	Initiative Requirement	Second Year Phase-In	Third Year Phase-In
<u>Investment</u>					
	Marginal		(98,425)		
	TPC		378,352		
	Capital				
	Labor				
	Travel				
	Resource Support/Local Contract				
	Supplemental Care				
	Miscellaneous				
Direct Care Net or Net Investment		\$ -	\$ 279,927	\$ -	\$ -
<u>Savings/Cost Avoidance</u>					
Change in Direct Care:		Savings (+) / Cost (-)			
MCS Contract Impact:		Savings (+) / Cost (-)			
*Net Value		\$ -	\$ 279,927	\$ -	\$ -

Base BCA Template 3.4 (BSC Rationalization)

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	Score					
Enter score here →	1					

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3. Financials (2 of 4)		Grade	4	3	2	1	0
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3.2 Reallocation Complexity							
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Medium	Doable with moderate impact of negative performance impact						
Low	Not doable or incurs significant risk of performance impact						
		Score					
		4					

Evaluation Criteria		Grade of Factors	High / High	Med/High High/Med	Med/Med High/Low	Low/Med Med/Low Low/High	Low/Low
3. Financials (4 of 4)		Grade	4	3	2	1	0
3.3 Profit Impact over 3 years							
High	+\$500 k	X					
Medium	\$200k+ and < \$500k						
Low	< \$200						
3.4 Timeframe							
High	75% of profit impact achieved in < 1 year	X					
Medium	75% of profit impact achieved in < 2 years						
Low	75% of profit impact achieved in > 2 years						
		Score					
		3					

Evaluation Criteria		Grade of Factors	High / High	Med/High High/Med	Med/Med High/Low	Low/Med Med/Low Low/High	Low/Low
<b>4. Complexity to Implement</b>		Grade	2	1.5	1	0.5	0
<b>4.1. Interdependencies</b>		Score					
High	With proper governance and execution, the initiative can succeed in its own right	X					
Medium	Interdependence with other initiatives is significant, but manageable						
Low	Requires output and success of multiple other initiatives to succeed						
<b>4.2. Human Resource Requirements</b>							
High	Can be accomplished with existing people and skills	X					
Medium	Requires the investment of high-leverage outside resources in the short term						
Low	Requires a major, long-term investment in outside resources						
		Score					
		2					

Evaluation Criteria		Grade of Factors	All Four Boxes Checked	Any Three Boxes Checked	Any Two Boxes Checked	Any One Box Checked	No Boxes Checked
<b>4.3 Quality of Sponsorship</b>		Grade	2	1.5	1	0.5	0
1	Sponsor engaged	X					
2	Sponsor Accountable	X					
3	Project Manager in Place	X					
4	Critical mass of people aware & ready to participate	X					
		Score					
		2					

Evaluation Criteria		Grade of Factors	High / High	Med/High High/Med	Med/Med High/Low	Low/Med Med/Low Low/High	Low/Low
<b>5. Capabilities-Building Potential</b>		Grade	4	3	2	1	0
<b>5.1 Models Future Capabilities</b>							
High	Builds highly needed strategic capabilities or required for future success						
Medium	Builds lower priority capabilities that will be required for future success	X					
Low	Has little impact on building strategic capabilities						
<b>5.2 Time to Impact</b>							
High	The capabilities developed will have performance impact in FY01	X					
Medium	The capabilities developed will have performance impact within 2 years						
Low	The capabilities developed will have little impact in the next 2 years						
		Score					
		3					



**Appendix D  
OB/Gyn Calculations**

DOD/VA Sharing 90

**MAMC/VAPSHCS OB/Gyn Sharing Agreement Calculations**

First Visit - Outpatient	Most likely CPT Codes	Visits/ week	Visits/ year	CMAC Rate	Charges	Marginal Cost/visit	Total cost per year	Revenue
E&M Codes	99214	2	104	\$ 76.79	\$ 7,986.16	\$ 25.42	\$ 2,643.68	\$ 5,342.48
		3.5	182	\$ 76.79	\$ 13,975.78	\$ 25.42	\$ 4,626.44	\$ 9,349.34
		5	260	\$ 76.79	\$ 19,965.40	\$ 25.42	\$ 6,609.20	\$ 13,356.20
	99215	2	104	\$ 112.71	\$ 11,721.84	\$ 25.42	\$ 2,643.68	\$ 9,078.16
		3.5	182	\$ 112.71	\$ 20,513.22	\$ 25.42	\$ 4,626.44	\$ 15,886.78
		5	260	\$ 112.71	\$ 29,304.60	\$ 25.42	\$ 6,609.20	\$ 22,695.40
	Average	2	104	\$ 94.75	\$ 9,854.00	\$ 25.42	\$ 2,643.68	\$ 7,210.32
		3.5	182	\$ 94.75	\$ 17,244.50	\$ 25.42	\$ 4,626.44	\$ 12,618.06
		5	260	\$ 94.75	\$ 24,635.00	\$ 25.42	\$ 6,609.20	\$ 18,025.80
Catheterization	53670	2	104	\$ 79.83	\$ 8,302.32	\$ -	\$ -	\$ 8,302.32
		3.5	182	\$ 79.83	\$ 14,529.06	\$ -	\$ -	\$ 14,529.06
		5	260	\$ 79.83	\$ 20,755.80	\$ -	\$ -	\$ 20,755.80
First Visit Totals		2	104	\$ 174.58	\$ 18,156.32	\$ 25.42	\$ 2,643.68	\$ 15,512.64
		3.5	182	\$ 174.58	\$ 31,773.56	\$ 25.42	\$ 4,626.44	\$ 27,147.12
		5	260	\$ 174.58	\$ 45,390.80	\$ 25.42	\$ 6,609.20	\$ 38,781.60
Second Visit - Outpatient								
Urodynamics	min - 51741	2	104	\$ 56.53	\$ 5,879.12	\$ 25.42	\$ 2,643.68	\$ 3,235.44
		3.5	182	\$ 56.53	\$ 10,288.46	\$ 25.42	\$ 4,626.44	\$ 5,662.02
		5	260	\$ 56.53	\$ 14,697.80	\$ 25.42	\$ 6,609.20	\$ 8,088.60
	max - 51726	2	104	\$ 84.63	\$ 8,801.52	\$ 25.42	\$ 2,643.68	\$ 6,157.84
		3.5	182	\$ 84.63	\$ 15,402.66	\$ 25.42	\$ 4,626.44	\$ 10,776.22
		5	260	\$ 84.63	\$ 22,003.80	\$ 25.42	\$ 6,609.20	\$ 15,394.60
	Mean	2	104	\$ 75.67	\$ 7,869.68	\$ 25.42	\$ 2,643.68	\$ 5,226.00
		3.5	182	\$ 75.67	\$ 13,771.94	\$ 25.42	\$ 4,626.44	\$ 9,145.50
		5	260	\$ 75.67	\$ 19,674.20	\$ 25.42	\$ 6,609.20	\$ 13,065.00
Totals for Visits 1 and 2		2	208	\$ 250.25	\$ 26,026.00	\$ 50.84	\$ 5,287.36	\$ 20,738.64
		3.5	364	\$ 250.25	\$ 45,545.50	\$ 50.84	\$ 9,252.88	\$ 36,292.62
		5	520	\$ 250.25	\$ 65,065.00	\$ 50.84	\$ 13,218.40	\$ 51,846.60
Third Visit - Outpatient								
Procedure - Outpatient	min - 57240	2	104	\$ 393.23	\$ 40,895.92	\$ 25.42	\$ 2,643.68	\$ 38,252.24
		3.5	182	\$ 393.23	\$ 71,567.86	\$ 25.42	\$ 4,626.44	\$ 66,941.42
		5	260	\$ 393.23	\$ 102,239.80	\$ 25.42	\$ 6,609.20	\$ 95,630.60
	max - 51841	2	104	\$ 793.92	\$ 82,567.68	\$ 25.42	\$ 2,643.68	\$ 79,924.00
		3.5	182	\$ 793.92	\$ 144,493.44	\$ 25.42	\$ 4,626.44	\$ 139,867.00
		5	260	\$ 793.92	\$ 206,419.20	\$ 25.42	\$ 6,609.20	\$ 199,810.00
	Mean	2	104	\$ 664.95	\$ 69,154.80	\$ 25.42	\$ 2,643.68	\$ 66,511.12
		3.5	182	\$ 664.95	\$ 121,020.90	\$ 25.42	\$ 4,626.44	\$ 116,394.46
		5	260	\$ 664.95	\$ 172,887.00	\$ 25.42	\$ 6,609.20	\$ 166,277.80
Totals for Visits 1-3 Outpatient		2	312	\$ 915.20	\$ 95,180.80	\$ 76.26	\$ 7,931.04	\$ 87,249.76
		3.5	546	\$ 915.20	\$ 166,566.40	\$ 76.26	\$ 13,879.32	\$ 152,687.08
		5	780	\$ 915.20	\$ 237,952.00	\$ 76.26	\$ 19,827.60	\$ 218,124.40
Fourth Visit - Inpatient								
Procedure - Inpatient		2	21	\$ 2,700.00	\$ 56,160.00	\$1,511.48	\$ 31,438.78	\$ 24,721.22
		3.5	36	\$ 2,700.00	\$ 98,280.00	\$1,511.48	\$ 55,017.87	\$ 43,262.13
		5	52	\$ 2,700.00	\$ 140,400.00	\$1,511.48	\$ 78,596.96	\$ 61,803.04
Totals for All Visits		2			\$ 151,340.80		\$ 39,369.82	\$ 111,970.98
		3.5			\$ 264,846.40		\$ 68,897.19	\$ 195,949.21
		5			\$ 378,352.00		\$ 98,424.56	\$ 279,927.44

## Appendix D

## Definitions

**Access to Care.** This is a measure of the ability of a patient to obtain care based on the patient receiving care that is not offered, the service is offered but appointments are not available, and the amount of time the patient has to wait to get an appointment. An additional factor related to access is the time and distance a patient must travel in order to receive his care.

**Beneficiary Satisfaction.** This is how well the patient feels about the overall process of the care received. Factors affecting beneficiary satisfaction include (1) access, (2) feelings of ownership, belonging, and loyalty that patients have toward the institution, (3) quality and quantity of staff interaction with the patient, and of course (4) quality of care provided.

**Benefit to GME.** Both MAMC and VAPSHCS have GME programs. These programs require certain numbers of cases and patient contact hours for various residents to become board certified. Sharing agreements may help meet these requirements. Depending on the number of episodes of care, it may help expand individual GME programs.

**Benefit to Taxpayers, Congress, and other Stakeholders.** There are others who have a stake in what MAMC and VAPSHCS does and how they do it, not just the organizations themselves. It may cost MAMC more to provide a particular service to VAPSHCS, or vice-versa, than MAMC can recoup. The VAPSHCS however, may pay less to have MAMC provide care than it would pay to hire additional personnel themselves or to have a civilian facility provide the care. In this case MAMC may lose money, but its loss may end up being a savings for the VA, and a net savings for Congress and American taxpayers.

**Continuity of Care.** This is a measure of how well the patient's care is coordinated. Factors include: record availability and transfer of information, is the patient transferred many times to many locations, is there a single provider who is following the patient?

**Cost Avoidance.** This is the dollar amount the organization would "avoid" paying in the future, based on obtaining an equivalent volume and quality of care at a lower price through one alternative than it pays currently for that same care.

**Marginal Costs.** These are the costs associated with performing one additional unit of service, i.e., seeing one additional patient. Given this particular situation, the only real additional costs incurred by either the VA or MAMC are the cost of supplies, medications, and ancillary services associated with a particular episode of care. Property, plant, and equipment (PPE) costs, personnel salaries, utilities, etc., are costs that the organizations already incur on a daily basis and are therefore not considered.



## Appendix E

## Acronyms

ADS – Ambulatory Data System  
ALOS – Average Length of Stay  
AMEDD – Army Medical Department  
APCC – Adult Primary Care Clinic  
ARS – All Regional Server  
ASD(HA) – Assistant Secretary of Defense for Health Affairs  
BCA – Business Case Analysis  
BSC – Balanced Scorecard  
CHCS – Composite Health Care System  
CHF – Congestive Heart Failure  
CMAC – Champus Maximum Allowable Charge  
CME – Continuing Medical Education  
CMOP – Consolidated Mail-Order Pharmacy  
CPT – Current Procedural Terminology  
DCCS – Deputy Commander for Clinical Services  
DOD – Department of Defense  
DRG – Diagnosis Related Group  
DSCP – Defense Supply Center Philadelphia  
DVA – Department of Veterans Affairs  
EAS – Expense Assignment System  
ENT – Ear, Nose, and Throat  
FFS – Fee for Service  
FTE – Full-Time Equivalent  
FY – Fiscal Year  
GAO – United States General Accounting Office  
GME – Graduate Medical Education  
GMP – Graduate Management Project  
FSS – Federal Supply Schedule  
HMO – Health Maintenance Organization  
HNFS – Health Net Federal Services  
HR – United States House of Representatives  
ICDB – Integrated Clinical Database  
ICU – Intensive Care Unit  
IM/IT – Information Management/Information Technology  
IV – Intravenous  
LPN – Licensed Practical Nurse  
MAMC – Madigan Army Medical Center  
MCSC – Managed Care Support Contractor  
MEPRS – Medical Expense and Performance Reporting System  
MEQS – MEPRS Executive Query System  
MHS – Military Health System  
MOU – Memorandum of Understanding

MS – Medical Service Corps  
MTF – Military Treatment Facility  
NDMS – National Disaster Medical System  
OB/Gyn – Obstetrics and Gynecology  
OR – Operating Room  
ORMA – Operating Room Management Application  
OSD(HA) – Office of the Assistant Secretary of Defense for Health Affairs  
OTSG – The Office of the Surgeon General (Army)  
PAD – Patient Administration Division  
PASBA – Patient Administration Systems and Biostatistics Activity  
PCM – Primary Care Manager  
PERSCOM – United States Army Personnel Command  
PPO – Preferred Provider Option  
PROFIS – Professional Filer System  
RMC – Regional Medical Command  
RMD – Resource Management Division  
RN – Registered Nurse  
ROI – Return on Investment  
TSG – The Surgeon General of the Army  
VA – Department of Veterans Affairs  
VAPSHCS – Department of Veterans Affairs Puget Sound Health Care System  
VBA – Veterans Benefits Administration  
VHA – Veterans Health Administration  
VISN – Veterans Integrated Service Network  
WRMC – Western Regional Medical Command  
WWR – Worldwide Workload Report